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

DUSTIN DYAS,

Petitioner,

vs.

NO: 15 WC 13955

RETROFOAM,

18IWCC0413

Respondent.

DECISION AND OPINION ON REVIEW

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

The arbitrator awarded reimbursement to BlueCross BlueShield, Petitioner's health insurance carrier, for certain medical payments made. Payment for this claim is being satisfied by the Illinois Insurance Guaranty Fund by virtue of Respondent's private insurance carrier being liquidated on May 23, 2016. The payments made by BlueCross BlueShield results from the same facts and injury that gives rise to this matter. Petitioner was first required to exhaust medical benefits under the BlueCross BlueShield policy at issue. The Commission therefore modifies the arbitrator's award to deny Petitioner's claim for reimbursement to Blue Cross Blue Shield as reflected in Petitioner's Exhibit 10.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $245.65 per week for a period of 24 weeks, as provided in §8(d) 2 of the Act, for the reason that the injuries sustained caused the 5% loss of use of the person as a whole for four spinal fractures. Respondent is not due any overpayment credit for overpayment of

18IWCC0413

permanent partial disability payments.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay directly to Petitioner' providers reasonable and necessary medical expenses as set forth in Petitioner's Exhibit 10, the lesser amount actually paid for the services or the amount set forth in the medical fee schedule, under §8(a) of the Act, less the amount of $5,525.17 paid by Blue Cross/ Blue Shield of Illinois on Petitioner's behalf to various medical providers.

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 $60,000. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 2 - 2018
o- 5/3/18
SM/msb
44

Stephen J. Mathis
Stephen Mathis

David L. Gore
David L. Gore

Deborah L. Simpson
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DYAS, DUSTIN
Employee/Petitioner

Case# **15WC013955**

RETROFOAM
Employer/Respondent

18IWCC0413

On 9/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% 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:

2217 SHAY & ASSOCIATES
KATHERINE E WOOD
1030 DURKIN DR
SPRINGFIELD, IL 62704

2461 NYHAN BAMBRICK KINZIE & LOWRY
BRIAN T RATERMAN
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

18IWCC0413

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

DUSTIN DYAS
Employee/Petitioner

v.

RETROFOAM
Employer/Respondent

Case # 15 WC 13955

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **June 20, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 18IWCC0413

On January 28, 2015, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $10,071.38; the average weekly wage was $406.10.

On the date of accident, Petitioner was 21 years of age, *single* with 1 dependent children.

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

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

Respondent shall be given a credit of $11,541.46 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $0.

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 10, directly to the providers, according to the fee schedule, as provided in Section 8(a) of the Act.

Respondent shall reimburse Blue Cross Blue Shield for payments made for reasonable and necessary medical services as set forth in Petitioner's Exhibit 10, the lesser of the amount actually paid for the services or the amount set forth in the fee schedule, as provided in Section 8(a) of the Act.

Permanent Partial Disability

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 3% of the thoracic spine and 1% of the pelvis as determined by Dr. Timothy Payne, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. RX 1. The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The doctor noted that Petitioner did have continued symptoms of stiffness in his low back with bending, as well as limited range of motion in the left hip. Notably, the limited range of motion is not considered as part of the impairment rating of the pelvis under the AMA Guidelines Because the Petitioner's most significant problem as to the pelvis is not considered as part of the impairment evaluation, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as an insulation installer at the time of the accident and that he *is* able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that the Petitioner did not in fact return to his prior employment for reasons unrelated to the accident. Currently, Petitioner works for a pizza restaurant, and is able to work that job full duty without problem. Because the Petitioner has been able to return

to work full duty and does not appear to have any pain, problems or limitations because of the accident, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 21 years old at the time of the accident. Although the Petitioner generally does not have any limitations with his work because of his accident, he does have some limited range of motion in the left hip and has pain and stiffness in his lower back with extended bending, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner was returned to full duty work after his accident, and has returned to work in full duty capacity, although with a different employer. Because Petitioner has sustained no difference in earning capacity, the Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator focuses on the complaints and findings of near the end of Petitioner's significant medical treatment. When Petitioner presented to Dr. Williams on October 5, 2015, he complained of continued muscle soreness. PX 6. Upon discharge from physical therapy on September 24, 2015, at which time he transitioned to work hardening, the therapist noted Petitioner had failed to meet four out of six of his goals. PX 8. Further, in the discharge evaluation for occupational therapy on November 19, 2015, Petitioner reported pain at 2 out of 10 and noted continued mild soreness. PX 9. On November 20, 2015, Petitioner reported having a little pain in the lower back if he overworked himself. PX 6. Because of Petitioner's ongoing complaints even after significant physical and occupational therapy, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of the person as a whole for the injuries to the Petitioner's spine and pelvis in addition to statutory payments she has received. Respondent shall receive a credit of $5,895.60 representing statutory payments of 24 weeks for the four spinal fractures at the rate of $245.65 per week. However, as set forth below, Respondent is not due any overpayment credit for overpayment of statutory PPD benefits.

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

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

Edward Cee 9/14/17

Signature of Arbitrator Date

ADDENDUM

STATEMENT OF FACTS

The Petitioner testified that he is 25 years old and has a five-year-old daughter. He testified that he graduated Athens High School, and has not received any college credits or technical training since obtaining his diploma. He is currently employed at Gabatoni's Restaurant, a pizza place, where he makes pizzas, takes orders, makes deliveries, serves and busses tables, and bartends.

Previously, Petitioner worked at Retrofoam from August 2014 until his date of accident, January 28, 2015. He testified that he worked at Retrofoam installing insulation. He testified that on January 28, 2015, he was working in the pool room of a new construction Holiday Inn Express in Litchfield, Illinois. He testified he was hanging plastic on an approximately twelve-foot ceiling. He was standing on a six-foot, A-frame ladder, when the ladder slipped from underneath him and he fell. Petitioner testified that he landed on his "butt" on concrete.

Immediately after the accident, Petitioner was driven to Springfield by his boss for medical treatment. He testified that he was initially taken to a prompt care facility, but was instructed by personnel there that he would need to go to the hospital as a trauma case.

Petitioner was then taken to Memorial Medical Center, where he was examined by Dr. David Beal. PX 2. He reported a history of fall from a six-foot ladder onto his tailbone. PX 2. He complained of pain in his tailbone. PX 2. Dr. Beal ordered CT examinations of the cervical, thoracic, and lumbar spine, as well as the chest, abdomen and pelvis. PX 2. The CT of the thoracic spine revealed an acute mild compression fracture of the T9 vertebral body, an acute burst fracture of the T11 vertebral body, with mild to moderate loss of height anteriorly and a 4 mm bony retropulsion into the spinal canal, age indeterminate mild height loss in the T3 and T4 vertebral bodies, chronic appearing mild height loss of the T12 vertebral body, and a prevertebral soft tissue hematoma at T9 through T11-12. PX 4. The CT of the pelvis revealed acute left inferior sacral and left iliac fractures, and also identified the T9 and T11 vertebral body fractures shown on the thoracic imaging. PX 3. Subsequently, Petitioner underwent an MRI of the thoracic spine, which showed the burst fraction at T11 and compression fracture at T9, but also revealed additional compression fractures of the T10 and T12 vertebral bodies. Petitioner testified that prior to this accident he had never been diagnosed with fractures to his pelvis or back and had never had any other injuries involving the pelvis or the back.

Petitioner was evaluated by Dr. Brett Wolters while at the hospital for an orthopedic consult. PX 2. Petitioner noted back and coccyx pain. PX 2. On physical examination, Dr. Wolters noted pain on palpation over the lower lumbar spine. PX 2. Dr. Wolters admitted Petitioner to the trauma ward. PX 2.

On January 29, 2015, Petitioner was discharged from Memorial Medical Center. PX 2. Prior to discharge, Petitioner was instructed to follow up with Dr. Wolters and was given a referral to Dr. Joseph Williams for his spine. Petitioner was fitted for a TLSO brace. Petitioner testified that the brace "was like a shell that encased your whole body." He testified that the brace was both front and back, and spanned from the "top of the chest to right above the - - right at the hip." Petitioner testified the he wore the brace for two-and-half months continually, and that he was not able to take the brace off while he was at home. The instructions for TLSO brace use set forth in the discharge instructions indicate that Petitioner was to wear the TLSO at all times, and that he may remove the front and back one at a time for sponge bathing, but that he was not to remove both the front and back at the same time.

Petitioner testified that he was kept off work after his accident. He was paid temporary total disability benefits by the Respondent for the time he missed from work.

On February 3, 2015, Petitioner presented to Dr. Joseph Williams, an orthopedic surgeon, for evaluation of his spine fractures. PX 6. Petitioner reported pain in the thoracic spine rated at 7 out of 10, but noted no radicular symptoms. PX 6. Dr. Williams performed an examination of Petitioner, which was normal. PX 6. He further took x-rays in office, which showed a burst fracture at T11 and compression fractures at T9, T10 and T12. PX 6. Dr. Williams noted no change in findings from Petitioner's prior films. PX 6. Dr. Williams diagnosed Petitioner with thoracic spine pain, burst fracture of the thoracic vertebra, and thoracic compression fractures. PX 6. Dr. Williams opined that Petitioner was not in need of surgery at that time. PX 6. He recommended continued use of the TLSO brace, which he expected Petitioner to wear for two and one half months. PX 6. Dr. Williams placed Petitioner off work until further evaluation. PX 6.

Petitioner returned to Dr. Williams on February 17, 2015. Petitioner reported pain when sleeping and when he first woke up. PX 6. He reported his pain was located in the posterior low back and rated it at 5 out of 10. PX 6. X-rays were taken of the thoracic spine, which showed no significant changes and signs of healing. PX 6. Petitioner reported he continued to wear his brace and continued activity restrictions. PX 6. Dr. Williams noted it was important Petitioner continue to use his TLSO brace. PX 6. Dr. Williams restricted Petitioner's activity to no repetitive lifting, bending, or twisting, and no lifting more than 10 pound. PX 6. He further continued to restrict Petitioner from work entirely. PX 6.

On February 27, 2015, Petitioner presented to Dr. Brett Wolters at Springfield Clinic for follow-up evaluation of his pelvic fractures. PX 6. Petitioner reported he was not having any problems with the left sacral olla and iliac wing fractures. PX 6. Dr. Wolters performed a physical examination, which revealed pain with trip impingement testing as well as scarring testing on the left side. PX 6. Follow-up x-rays were taken of the pelvis, which showed no evidence of displacement of the fractures. PX 6. Dr. Wolters recommended conservative management of the sacral and iliac fractures, and noted that he did not believe Petitioner required any further treatment specifically for these fractures has his activities were being restricted due to his spinal injuries. PX 6.

Petitioner returned to Dr. Williams on March 17, 2015. Petitioner noted pain in his low back that was very mild at 2 out of 10. He noted that his pain occurred most of the day. PX 6. X-rays were taken which showed stable fractures. PX 6. Dr. Williams recommended Petitioner wear the TLSO brace for the next two weeks, until his follow-up appointment, and continued to keep Petitioner off work. PX 6.

On April 6, 2015, Petitioner returned to Dr. Williams. PX 7. Petitioner noted he was not experiencing any pain, but was having some discomfort in the spine. PX 6. X-rays taken in office continued to show stable alignment in the spine. PX 6. Dr. Williams discontinued use of the TLSO brace, and placed Petitioner on restrictions of no repetitive lifting, bending, or twisting, no lifting more than 20 pounds, and sit down work only. PX 6. Respondent was unable to provide work within these restrictions, but continued to pay Petitioner temporary total disability benefits.

Petitioner returned to Dr. Williams on May 15, 2015. Petitioner noted he was having pain a few times per week, and that his pain was exacerbated with standing and sitting for extended periods of time, rolling over in bed, and riding in a car. PX 6. Petitioner further reported he had been walking for exercise. PX 6. Petitioner explained his job duties with Respondent to Dr. Williams, noting it involved a lot of heavy lifting. PX 6. Dr. Williams recommended Petitioner undergo physical therapy in order to allow Petitioner to safely return to full duty work. PX 6. He continued to keep Petitioner off work. PX 6.

On May 26, 2015, Petitioner presented to Memorial Industrial Rehab for an initial physical therapy evaluation. PX 8. Petitioner reported that since his TLSO brace had been removed he was feeling weakness and pain in his back. PX 8. He noted in the past 24 hours his pain had reached 4 out of 10. PX 8. He further reported difficulty walking, pain at night, and difficulty sleeping. PX 8. The therapist noted minimal tenderness over the bilateral lumbar paraspinals on palpation, as well as 75% limited thoracic rotation. PX 8. He further noted that

Petitioner's functional movements were guarded. PX 8. The therapist initiated a plan for Petitioner to be seen 2-3 times per week for an initial period of four weeks. PX 8. Petitioner initiated physical therapy on May 28, 2015 and continued to receive physical therapy until September 24, 2015. PX 8.

On June 15, 2015, Petitioner returned to Dr. Williams. He reported pain in his low back and "a little tightness in the thoracic area." PX 6. He rated his pain at 2-3 out of 10. PX 6. He reported his pain was relieved by NSAIDs and that he had been taking Ibuprofen. PX 6. Petitioner reported that he had undergone four weeks of physical therapy, which had provided relief. PX 6. Dr. Williams continued physical therapy for two weeks. PX 6.

Petitioner returned to Dr. Williams on July 27, 2015, reporting he had completed physical therapy and that he was continuing to have pain a few times per week at a 1 out of 10. PX 6. However, Petitioner reported he was no longer taking any pain medicine. PX 6. Dr. Williams continued Petitioner's physical therapy and continued to keep him restricted from work. PX 6.

On September 8, 2015, Petitioner returned to Dr. Williams. PX 6. Petitioner reported no pain at that time. PX 6. However, he reported he was still unable to do a sit up and attempts caused pain. PX 6. He further reported pain when attempting to lift. PX 6. He was concerned that if he returned to work at that time, he would only be able to perform part of his job duties. PX 6. However, he did report he wished to return to his employment and that he enjoyed the work. PX 6. Dr. Williams recommended continued therapy, and recommended he return in one month, with the hope he would be able to return to work at that time. PX 6.

Petitioner returned to Dr. Williams on October 5, 2015. He complained of muscle soreness, but denied pain. PX 6. Dr. Williams recommended that Petitioner transition from physical therapy to work hardening in an effort to get him back to work. PX 6.

Petitioner was discharged from physical therapy on September 24, 2015, in order to transfer to work hardening, which he began on October 1, 2015 at Memorial Industrial Rehab. PX 8, PX 9. The discharge notes from the physical therapist noted that Petitioner had 30 out of 31 appointments, but had only met 2 out of his 6 goals. PX 8. Petitioner subsequently received occupational therapy until November 19, 2015. PX 9. During his discharge evaluation, Petitioner reported pain at 2 out of 10, noting he was "a little sore but noting too bad." PX 9. The therapist noted in his discharge note that Petitioner was "motivated and challenged himself throughout the therapy program." PX 9. Petitioner met all of his occupational therapy goals. PX 9. Further, Petitioner was instructed to continue home exercises. PX 9.

Petitioner returned to Dr. Williams on November 20, 2015. PX 6. He noted he had completed therapy and that it had been helpful. PX 6. He reported he was able to lift 85 pounds from the floor to his waist and indicated he was doing well. PX 6. The Petitioner testified at hearing that he was feeling much better at this time. He testified that he would have a little pain in his lower back if he overworked himself. Dr. Williams recommended a trial return to work without restrictions at this time. PX 6. The Petitioner testified that, at the time of his release to return to work, he felt physically able to return to his duties at Retrofoam, but that he was unable to return to his employment with Retrofoam for unrelated reasons.

On January 11, 2016, Petitioner had his last appointment with Dr. Williams. PX 6. He reported completing physical therapy. PX 6. At this time, Petitioner was released from care and placed at maximum medical improvement. PX 6.

On April 15, 2016, Petitioner presented to Dr. Timothy Payne, at the request of the Respondent for an Independent Medical Examination and AMA Impairment Rating. Dr. Payne testified via his evidence deposition, taken on June 7, 2017, and entered into evidence as Respondent's Exhibit 1. Dr. Payne testified he

practices general orthopedics and is board certified in orthopedic surgery. RX 1, pp. 5-6. Upon presenting to Dr. Payne, Petitioner noted that he would experience stiffness and pain across his lower back if he was bending or stooping for twenty to thirty minutes. RX 1, pp. 12-13. He further reported left hip stiffness with motion. RX 1, p. 13.

Dr. Payne performed a physical examination as part of his evaluation. RX 1, p. 14. Dr. Payne noted that Petitioner did not have any signs of symptom magnification. RX 1, p. 14. His examination of the spine was essentially normal. RX 1, p. 14. With regards to the hip, the Petitioner exhibited some stiffness with rotation of the left hip with the Faber maneuver. RX 1, p. 15. Further, the left hip showed decreased external rotation of 30 degrees on the left verses 45 degrees on the right, and decreased internal rotation of 20 degrees on the left verses to 30 degrees on the right. RX 1, p. 15. Dr. Payne testified that Petitioner may continue to have some residual stiffness or tightness based on activity indefinitely. RX 1, p. 42.

Dr. Payne noted he reviewed the report of the MRI taken of Petitioner's thoracic spine. RX 1, p. 18. He noted the MRI showed a mild burst fracture at T11 with minimal retropulsed fragments, mild compression fractures at T9 and T10, and edema at T12. RX 1, p. 18. Dr. Payne testified that a retropulsed fragment on the spine is similar to a crack in an eggshell, where the fragment is still attached, but is partially pulled away from the rest of the structure. RX 1, p. 38. Dr. Payne testified this can cause problems, and it was likely the reason Petitioner was placed in the TLSO brace. RX 1, p. 39. Dr. Payne noted that the retropulsed fragment had healed in a way that it did not cause clinical symptoms, although there was some change in the anatomy. RX 1, p. 39. He further noted reviewed thoracic spine x-rays of the thoracic spine, Pelvis, and lumbar spine. He noted in addition to the spinal fractures, he noted fractures of the left ala and left iliac wing. RX 1, p. 19. Dr. Payne testified that the ala and iliac wing fractures were not one continuous fracture across multiple bodies, but rather were two different fractures. RX 1, p. 40.

Dr. Payne diagnosed Petitioner with compression fractures of T9, T10, T11 and fractures of the left ala and iliac wing. RX 1, p. 22. He noted that the fractures had healed. RX 1, p. 22. Dr. Payne opined that these fractures were all caused by the fall Petitioner had sustained at work. RX 1, p. 23. Dr. Payne further agreed that Petitioner's treatment was reasonable and necessary. RX 1, pp. 23-24. He further noted that due to the trauma Petitioner had sustained, there may be future issues with degeneration of the spine. RX 1, p. 25. He further noted that Petitioner may have some future problems with whether changes. RX 1, pp. 25-26. Additionally, he noted that petitioner may develop pain in the back because of inactivity, and may develop some stiffness in the hips due to the fracture in the ala. RX 1, p. 26. Dr. Payne testified that these potential future problems would not be expected if he had not had the fractures. RX 1, p. 40.

Dr. Payne testified that he performed impairment ratings as to the thoracic spine and pelvis. RX 1, p. 28. He agreed that impairment does not equal disability. RX 1, p. 28. Petitioner completed a pain disability questionnaire, which rendered a total pain disability score of seven. RX 1, p. 31. Dr. Payne testified that he used page 568, table 17-3, the Thoracic Spine Regional Grid: Spine Impairment for impairment rating of the thoracic spine. RX 1, p. 32, 35. He used the diagnosis of "Single or Multiple Level Fractures, less than 25 percent of any vertebral body." RX 1, p. 32. This placed Petitioner in Class 1, with a disability range of 2-6, with a default rating of 4. RX 1, pp. 32-33. Dr. Payne noted he only used two grade modifiers, as the clinical study modifier was used in rendering the diagnosis. RX 1, p. 43. With regards to the functional history, he looked to the pain disability questionnaire, which he noted provided a modifier of 1, as he had minimal impairment based on the questionnaire. RX 1, p. 33. For the physical exam modifier, he gave a score of 0 as there were no findings as to the spine. RX 1, p. 33. Dr. Payne gave a total rating of 3% for the spine.

With regards to the pelvis, Dr. Payne used Table 17-11, page 593, Fracture of the Ilium, and found it was a Class 1 based on a non-displaced fracture, which has a default value of 2. RX 1, p. 36. Again, Dr. Payne did not use the clinical study modifier as it was used in rendering the diagnosis. RX 1, p. 43. Further, he did not use the

pain disability questionnaire for the functional history modifier, as it had been used in his evaluation of the spine, and he testified that he was unable to use it for both. RX 1, p. 36. He granted a physical exam modifier of 0. RX 1, p. 36. Dr. Payne testified that the physical exam adjustment did not take into consideration limitations in range of motion. RX 1, p. 45. Dr. Payne found Petitioner had an impairment rating of 1 percent as to the pelvis. RX 1, p. 36.

Dr. Payne testified that he performs approximately five independent medical evaluations per week. RX 1, p. 7. He further testified that he charges $1200 for an IME, but in cases where he evaluates two different body parts, the charge is $1500. RX 1, p. 45.

Petitioner testified that his back still bothers him occasionally. He testified that prolonged bending will cause pain.

CONCLUSIONS OF LAW

Issue F: Is the Petitioner's Current Condition of Ill-Being Causally Related to the Injury?

The Arbitrator finds that the Petitioner's current conditions of fractures to T9, T10, T11, T12 of the thoracic spine and to the left ala and iliac wing of the pelvis are causally related to his work accident of January 28, 2015.

The medical evidence is undisputed as the causal relationship for the pelvic fractures and the fractures to T9, T10, and T11. With regards to the fracture to T12, the Petitioner underwent several radiological studies to his thoracic spine at Memorial Medical Center on the date of his accident. PX 2. The CT of the thoracic spine only showed fractures of T9 and T11. PX 2. However, a subsequent MRI was taken revealed fractures at T9, T10, T11, and T12. PX 2. Further, when Petitioner initially presented to Dr. Williams on February 3, 2015 for evaluation of his spine, he took x-rays in office which showed a burst fracture at T11 and compression fractures at T9, T10, and T12. PX 6.

While Dr. Payne did not render a diagnosis of T12 fracture upon his independent medical examination, it is clear based on the evidence from Petitioner's MRI and the x-rays taken by Dr. Williams on February 3, 2015 that Petitioner did in fact sustain a T12 fracture as a result of the accident. The Arbitrator, therefore, finds that the Petitioner did sustain a fracture to T12 as a result of the January 28, 2015 accident.

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?

Dr. Payne testified that all of Petitioner's medical treatment has been reasonable and necessary. RX 1, p. 23-24. Therefore, the Arbitrator finds that all Petitioner's medical treatment has been reasonable and necessary. The Petitioner's medical bills are set forth in Petitioner's Exhibit 10. The Respondent is ordered to pay Petitioner's medical bills, as set forth in Petitioner's Exhibit 10, directly to the providers, according to the fee schedule, as set forth in the Act.

Issue L: What is the Nature and Extent of the Injury?

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 3% of the thoracic spine and 1% of the pelvis as determined by Dr. Timothy Payne, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. RX 1. The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation.

The doctor noted that Petitioner did have continued symptoms of stiffness in his low back with bending, as well as limited range of motion in the left hip. Notably, the limited range of motion is not considered as part of the impairment rating of the pelvis under the AMA Guidelines Because the Petitioner's most significant problem as to the pelvis is not considered as part of the impairment evaluation, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as an insulation installer at the time of the accident and that he *is* able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that the Petitioner did not in fact return to his prior employment for reasons unrelated to the accident. Currently, Petitioner works for a pizza restaurant, and is able to work that job full duty without problem. Because the Petitioner has been able to return to work full duty and does not appear to have any pain, problems or limitations because of the accident, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 21 years old at the time of the accident. Although the Petitioner generally does not have any limitations with his work because of his accident, he does have some limited range of motion in the left hip and has pain and stiffness in his lower back with extended bending, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner was returned to full duty work after his accident, and has returned to work in full duty capacity, although with a different employer. Because Petitioner has sustained no difference in earning capacity, the Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator focuses on the complaints and findings of near the end of Petitioner's significant medical treatment. When Petitioner presented to Dr. Williams on October 5, 2015, he complained of continued muscle soreness. PX 6. Upon discharge from physical therapy on September 24, 2015, at which time he transitioned to work hardening, the therapist noted Petitioner had failed to meet four out of six of his goals. PX 8. Further, in the discharge evaluation for occupational therapy on November 19, 2015, Petitioner reported pain at 2 out of 10 and noted continued mild soreness. PX 9. On November 20, 2015, Petitioner reported having a little pain in the lower back if he overworked himself. PX 6. Because of Petitioner's ongoing complaints even after significant physical and occupational therapy, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent 5% loss of use of the person as a whole for the injuries to the Petitioner's spine and pelvis. Respondent shall receive a credit of $5,895.60 representing statutory payments of 24 weeks of permanent partial disability for the four spinal fractures at the rate of $245.65 per week. However, as set forth below, Respondent is not due any overpayment credit for overpayment of statutory PPD benefits.

Issue N: Is the Respondent Due Any Credit?

As to Issue N, the Arbitrator finds that the Respondent is not due credit for overpayment of statutory ppd. As noted in Issue F above, the radiological studies clearly show that Petitioner sustained four fractures to the thoracic spine. PX 2, PX 6.

The Respondent paid statutory permanent partial disability for four spinal fractures. As the Arbitrator finds that the Petitioner in fact had four spinal fractures and Respondent paid for four spinal fractures, the Arbitrator finds that the Respondent is not due any credit for statutory overpayment.

Issue O: How Many Dependents Does the Petitioner Have?

As to issue O, the Arbitrator finds that the Petitioner has one dependent. The Petitioner testified that he has a five year old daughter. The Arbitrator finds the Petitioner's testimony to be credible. The Respondent has provided no evidence to contradict the Petitioner's testimony. Therefore, the Arbitrator finds that, for purposes of determining the minimum rate for permanent disability, the Petitioner has one dependent in addition to himself.

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

Reyna Olvera,
Petitioner,
vs.

NO: 15 WC 12191

Labor Network,
Respondent.

18IWCC0414

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 13, 2017, is hereby affirmed and adopted.

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

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

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

JUL 2 - 2018

DATED:
o062818
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

OLVERA, REYNA
Employee/Petitioner

Case# **15WC012191**

LABOR NETWORK INC
Employer/Respondent

18IWCC0414

On 12/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

0815 ACEVER & PEREZ PC
EMILIANO PEREZ JR
1931 N MILWAUKEE AVE
CHICAGO, IL 60647

5001 GAIDO & FINTZEN
ALEX L OTTENHEIMER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Olvera, Reyna
Employee/Petitioner

v.

Labor Network, Inc.
Employer/Respondent

Case # 15 WC 12191

Consolidated cases: _____

18IWCC0414

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **08/16/17 & 08/22/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 18IWCC0414

On the date of accident, **10/03/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$28,822.04**; the average weekly wage was **$554.27**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$2,171.42** for TTD, **$0** for TPD, **$0** for maintenance, and **$9,429.33** for other benefits, for a total credit of **$11,600.75**.

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 $369.51/week for 126-6/7 weeks, commencing 03/20/15 through 08/22/17, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $35,046.26, as provided in Sections 8(a) and 8.2 of the Act.

Respondent under section 8(a) shall provide written authorization & pay for the arthroscopic surgery as recommended by Drs. Westin and Silver plus all ancillary pre and post surgical care per the doctors.

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

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

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

#01 George Andros

Signature of Arbitrator

12/12/17
Date

ICArbDec19(b)

DEC 13 2017

FINDINGS OF FACT 15 WC 012 191

This matter was originally tried before Arbitrator Williams on August 23, 2016. As is their right, Respondent demanded that this matter be re-tried.

Petitioner testified at hearing through a Spanish interpreter that she was a 52 year-old married female at the time of this accident. (Tr. 5) Petitioner testified that Respondent's business is in packing and that she was employed as a packer/quality control on an assembly line. The Arbitrator finds as per the Application she was a loaned employee from Labor Network to Cloverhill Bakery. (Tr. 6) Her shift during the time of this accident was from 6:00 p.m. to 6:00 a.m. On the date of this undisputed accident, Petitioner was injured when she struck her right knee on a metal lever under the assembly line she working on.

Petitioner described the metal lever as squared shaped and 12-14 centimeters in size. (Tr. 8) She testified that she felt immediate and severe pain to her right knee (Tr. 9).

It was Petitioner's uncontroverted testimony that she reported this incident that same day to her supervisor, Luis Reyes. (Tr. 9) She testified that Mr. Reyes provided her with an ice pack and told her to sit for a while. (Tr. 10) According to Petitioner, Mr. Reyes further told her he would refer her to the company clinic. Petitioner testified that she finished her shift and continued to work full-duty until she was referred to Occupational Health Centers (company clinic) on October 16, 2014. Petitioner explained the two-week delay as waiting for Respondent to schedule the appointment. (Tr. 10-11) No one from Respondent testified to the contrary.

On October 16, 2014, Petitioner was evaluated by Dr. Eric Griffin at Occupational Health Centers. (PX1, pg. 1) A consistent history of striking her knee on a metal switch handle while working on the assembly line was provided. (Id.)

The record indicates that Petitioner continued to work full-duty for two weeks following this accident, but that her knee became progressively worse. (Id.) The pain in her knee was described as "persistent and intermittent." Dr. Griffin noted tenderness anteriorly and over the patella. (Id.) Dr. Griffin prescribed Naproxen 220, physical therapy and ordered Petitioner to restricted work (no prolonged standing/walking, no squatting, no kneeling and no climbing stairs). (PX1, pg. 2)

On October 18, 2014, Petitioner was re-evaluated by Dr. Sakthi Arigovindan at Occupational Health Centers. (PX1, pg. 3) It was noted that Petitioner continued with complaints to the anterior aspect of the patellar tendon. (Id.) Consistent with her testimony at hearing, she complained then of increased symptomology with activities such as walking and walking up stairs.

On October 25, 2016, Petitioner was re-evaluated by Dr. Mahmuda S. Mohsin of Occupational Health Centers. (PX1, pg. 5) It was noted that Petitioner's symptoms had not improved and that palpation of the knee revealed tenderness of patellar area in the medial joint line and lateral joint line of the right knee. (Id.) Petitioner was advised to continue with the prescribed restrictions and medication. She was also prescribed a knee brace.

On November 3, 2014, Petitioner was re-evaluate by Dr. Osama H. Thaji of Occupational Health Centers. (PX1, pg. 7) Dr. Thaji noted positive McMurray's test with tenderness of the patellar tendon and at the lateral joint line. Petitioner was provided that same restrictions and encouraged continued use of the brace. (PX1, pp. 7-8)

On October 8, 2014, Petitioner was re-evaluated by Dr. Deborah J. O'Brien of Occupational Health Centers (PX1). Petitioner indicated some improvement and a willingness to try full-duty work. (PX1, pg. 9)

On November 12, 2014, Petitioner's physical therapy order was approved and she began physical therapy at Athletico. (PX2) The records indicate that Petitioner presented to the clinic with "pain and tenderness to palpation over anterolateral knee, patellar hypomobility, and strength deficits throughout the right leg." (PX2, pg. 15) Athletico noted 16 different tasks required of a packer. Of note, it was determined that Petitioner was either unable to perform or severely limited in performing all tasks. (PX2, pg. 18)

On November 15, 2014, Petitioner was re-evaluated by Dr. Jeneson Abraham of Occupational Health Centers. (PX1) It was noted that Petitioner continued to have moderate to severe symptoms to the right knee. (PX1, pg. 10) Dr. O'Brien further noted decreased range of motion and tenderness. (Id.) Petitioner was provided work restrictions of no squatting, no kneeling, no climbing stairs and no climbing ladders. (PX1, pg. 12)

On November 22, 2014, Petitioner was re-evaluated by Dr. Eugene Gaertner of Occupational Health Centers. (PX1) It was noted that Petitioner still had persistent pain to the right side of her right knee. (Px1, pg. 13) Dr. Gaertner noted "diffuse anterior knee and diffuse lateral knee." (PX1, pg. 14) Petitioner's work restrictions remained the same.

On November 29, 2014, Petitioner was re-evaluated by Dr. Victoria Wolfinger of Occupational Health Centers. (PX1) Due to the persistent symptoms, Dr. Wolfinger referred Petitioner to an orthopedic specialist. (PX1, pg. 17). Petitioner's work restrictions remained the same. (Id.)

On December 5, 2014, Petitioner was evaluated by Craig Westin, M.D. of US MedGroup of Illinois, P.C. (company clinic). (PX3) Dr. Westin noted the right knee to be "tender to the lateral tibial femoral joint." (PX3, pg. 1) Dr. Westin further noted that Petitioner had no prior history of right knee issues, but now reports her knee to give out 4-5 times per day. Dr. Westin terminated the physical therapy order, but kept the same work restrictions in place. He also ordered an MRI of her right knee. (PX3, pg. 2)

On December 30, 2014, Petitioner underwent the recommended MRI at Advantage MRI. (PX4) The MRI revealed "11 by 8mm area of osteochondral signal abnormality within the femoral condyle..." (Id.) Petitioner was also suspected to have a Grade 2 sprain of the MCL and suspected sprain of the ACL. (Id.)

On January 6, 2015, Petitioner was re-evaluated by Dr. Westin. Dr. Westin opined that the MRI revealed osteochondral signal in the anterior medial femoral condyle. He opined that "[t]his could be from the accident striking her knee on a metal bar." (PX3, pg. 3) He administered a Xylocaine injection and ordered a follow-up on February 3, 2015. (Id.) The work restrictions remained the same.

On February 3, 2015, Petitioner was re-evaluated by Dr. Westin. Dr. Westin noted that Petitioner had "not shown significant improvement with therapy, cortisone injection, and anti-inflammatories." (PX3, pg. 4) Dr. Westin causally connected the symptoms to the work injury: **"The MRI does show a distinct lesion on the anteromedial femur. It is consistent with a blow over the knee described at the original injury by a metal bar."** [emphasis added] He recommended that "[d]ue to lack of improvement, arthroscopy, inspection of the joint, and treatment of the appropriate lesion...arthroscopy, debridement of osteochondral lesion, and probable debridement of synovial scar is recommended." (PX3, pg. 4)

The Arbitrator adopts this opinion by Dr Westin.

On March 20, 2015, Petitioner sought a second opinion with Dr. Ronald Silver. (PX5) Dr. Silver also causally connected the symptoms to her work injury. Like Dr. Thaji, Dr. Silver noted positive McMuarry's. (PX5, pg. 1) In agreement with Dr. Westin, he diagnosed Petitioner with osteochondral fracture in the medial femoral condyle and recommended arthroscopic surgery. (PX5, pg. 1) Dr. Silver ordered Petitioner to remain off work pending surgery. Petitioner testified that she has not worked since this day. Petitioner was referred by Dr. Silver to La Clinica, S.C. for additional physical therapy. (PX5, pg. 2)

Dr. Silver most recently reiterated his surgical recommendation on July 22, 2016. The Arbitrator adopts the opinions of Dr. Silver in the case at bar.

Petitioner testified that she wishes to undergo the surgery recommended by Drs. Westin and Silver. Petitioner further testified that she never suffered from any right knee pain nor has she ever sought any medical treatment prior to this accident.

The Resondent had the petitioner examined under section 12 by Dr. Bryan Forsythe on May 14, 2015. He finds at page 3 that Petitioner had a contusion. Further , he recommends not going ahead with the arthroscopy. The Arbitrator finds the opinions of the treating doctor(s) are much more persuasive in the case at bar. Dr. Forsythe is rejected as the MRI , see page 4 above , givens evidence more that Dr. Forysthe's contusion.The Utilization Report is taken into consideration in the case at bar. The ODG is not adopted by analyzed.

CONCLUSIONS OF LAW

With respect to Issue C, did Petitioner's injury arise out of and in the course of her employment with Respondent, the Arbitrator concludes:

The Arbitrator adopts the totality of the evidence in determining the Award. Key findings are cited above.

Further, the Arbitrator finds in the present case, Petitioner was injured while performing her duties on the assembly line. But for her work duties and the design of the machine she was working on, she would not have struck her knee causing the aforementioned injuries.

Based upon the totality of the evidence the arbitrator finds and holds Petitioner's work injury arose out of and in the course of her employment with Respondent , as alleged in the case at bar.

With respect to Issue E, whether timely notice of this accident was provided to the Respondent, the Arbitrator concludes:

Arbitrator concludes that Petitioner's testimony is credible that she gave notice to her supervisor, Luis Reyes, the same day the accident occurred is credible. Although Petitioner's unrebutted testimony alone is sufficient to justify an award, Petitioner's medical records are consistent that these injuries were caused by a work-related accident. Further, her testimony was subject of insightful cross examination yet further allowing the conclusion the testimony was credible.

Petitioner's medical records indicate that there was constant communication with the Respondent. (PX1) Respondent did not produce any witnesses to contradict Petitioner's assertion of notice. Furthermore, Petitioner's first five months of treatment occurred at the company clinic.

Based upon the totality of the evidence, the Arbitrator concludes and holds the Petitioner provided timely notice of this accident to the Respondent.

With respect to Issue F, whether Petitioner's condition of ill-being is causally related to the injury, the Arbitrator concludes:

Petitioner testified that she was able to complete her full-duty tasks prior to this accident. In fact, Petitioner testified and Respondent's own wage statement confirms that she worked plenty of overtime prior to October 3, 2014.

There is no evidence suggesting Petitioner had difficulty performing those duties or underwent any knee-related care prior to October 3, 2014.

Petitioner provided prompt notice of her accident and provided all physicians with a consistent account of her history. Both of her treating physicians, Drs. Westin and Silver, both independently

opined that she sustained injuries to her the anterior medial femoral condyle and requires arthroscopic surgery.

Based on the totality of the evidence , the Arbitrator finds and holds a causal connection exists between the work accident and Petitioner's current right knee condition.

With resect to Issue G, what were Petitioner's earnings, Arbitrator concludes:

Respondent offered into evidence a wage statement that totaled 207 days worked the previous 52 weeks with total gross earnings of $22,946.83. Pursuant to Sylvester v. Industrial Commission, 197 Ill.2d 225 (2001), the number of days worked (207) is to be divided by the 5-day workweek giving us a divisor of 41.4 weeks. The total earnings for the Petitioner preceding the work accident were $22,946.83. The amount earned ($22,946.83) divided by the divisor of 41.4 weeks provides an average weekly wage of $554.27. Petitioner's earnings include overtime that she testified was mandatory. This assertion was unrebutted.

Although Petitioner may not have always worked full work weeks, Sylvester does not distinguish lost time. Sylvester provides that Section 10 of the Act makes clear that "'lost time is to be deducted before the number of weeks and parts thereof...are divided into a claimant's earnings.'" Sylvester, at 235 (citing Cook v. Industrial Commission, 231 Ill. App. 3d 729).

Based upon the totality of the evidence, the Arbitrator concludes and holds that Petitioner's average weekly wage per section 10 under case law is $554.27.

With respect to Issue J, were the medical services that were provided reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Arbitrator concludes based on the totality of the evidence, the medical treatment that has been rendered has been reasonable and necessary. Arbitrator further concludes that Respondent has not paid all appropriate charges.

Accordingly, Arbitrator orders the Respondent to pay for and is liable for outstanding medical expenses pursuant to the fee schedule.

With respect to Issue K, whether Petitioner is entitled to prospective medical care, Arbitrator concludes:

Both of Petitioner's treating orthopedic surgeons, Drs. Westin and Silver, causally connected Petitioner's injury to the work accident and recommended arthroscopic surgery to her right knee. Respondent submitted Petitioner's request for right knee surgery through Utilization Review.

Based upon the totality of the evidence, Petitioner has proven by a preponderance of the evidence that she is entitled to the recommended right knee surgery. This is based on the more persuasive and adopted opinions of Drs. Westin and Silver, the positive MRI findings, causal connection and Petitioner's persistent pain complaints –all of which the Arbitrator adopts.

With respect to Issue J, is Petitioner entitled to temporary total disability benefits, Arbitrator concludes:

Since the date of this accident, Petitioner has been ordered by all physicians to either work with restrictions or remain off work entirely. Petitioner's testimony and the medical records are consistent with work aggravating her right knee condition.

Consequently, she was taken off work by Dr. Silver.

Based upon the totality of the evidence, the Arbitrator concludes and holds Petitioner is entitled to 126-6/7 weeks of temporary total disability benefits for the time she is ordered off work by Dr. Silver pending surgery.

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

Teresa Johnson,
Petitioner,
vs.

NO: 12 WC 28995

State of Illinois, DHS,
Respondent.

18IWCC0415

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 29, 2017, is hereby affirmed and adopted.

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

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

DATED: JUL 2 - 2018
o062818
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, TERESA
Employee/Petitioner

Case# **12WC028995**

STATE OF IL/DEPT OF HUMAN SERVICES
Employer/Respondent

18IWCC0415

On 12/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0400 LOUIS E OLIVERO & ASSOCIATES
DAVID W OLIVERO
1615 4TH ST
PERU, IL 61354

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

4138 ASSISTANT ATTORNEY GENERAL
WARREN WILKE
500 S SECOND ST
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

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

DEC 29 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Adams)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Teresa Johnson
Employee/Petitioner

v.

State of IL/Dept. of Human Services
Employer/Respondent

Case # 12 WC 028995

Consolidated cases: _____

18IWCC0415

An *Application for Adjustment 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 **Quincy**, on **November 1, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0415

FINDINGS

On **June 4, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$63,101.00**; the average weekly wage was **$1213.48**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **4** 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 **$14,331.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,331.20**.

Respondent is entitled to a credit of **for all medical payments made by its group health carrier** under Section 8(j) of the Act.

ORDER

Respondent shall receive a credit for all amounts paid on behalf of this claim. In no instance shall this credit supersede the amounts owed.

Respondent shall pay all reasonable, related, and necessary medical bills directly to the provider and pursuant to the fee schedule.

Respondent shall pay Petitioner, permanent partial disability benefits of $695.78 for 50 weeks as provided in Section 8(d)(2) of the Act because the injuries sustained caused a 10% 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.

Edward Lee

Signature of Arbitrator

12/17/17

Date

DEC 29 2017

Findings of Fact

The only disputed issues in this matter were those that pertained to what medical bills Respondent had paid or were in the process of being paid, and nature and extent. Accordingly, only those facts pertinent to a finding on the disputed issues will be discussed.

Petitioner is an employee of Respondent and claims she was injured at work on June 4, 2012 when door unexpectedly hit her in the back. Petitioner works as a Security Therapy Aid for the Department of Human Services at their Rushville facility.

Petitioner sought treatment for her back either on the date of her accident or the date after. After some conservative treatment, Petitioner underwent an MRI, which revealed a disc herniation at C5-6. Based on this MRI, Petitioner's Surgeon, Dr. Payne, recommended that Petitioner undergo a discectomy and fusion and the afflicted level.

Petitioner's surgery occurred on December 2, 2015. According to Petitioner, her surgery went well and she was eventually given a full-duty work release on February 27, 2016.

Petitioner's final physical therapy record, from February 23, 2016, indicates that Petitioner reported that she suffered from no pain and was able to do all of her household activities with no difficulty. (PX. 5 – 7th to last page).

Conclusions of Law

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

Respondent neither disputed liability as to reasonable, related, and necessary medical nor provided evidence that any of the bills Petitioner submitted were for treatment that was unreasonable, unrelated, or unnecessary. Accordingly, Respondent must pay all such medical bills to the provider pursuant to the fee schedule. Respondent is entitled to a credit for all bills it as already paid or for any bills that were paid through its group health provider.

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

Under Illinois Law, after a petitioner has concluded their medical treatment, and declared to be at MMI, that petitioner may seek additional compensation based on the nature and extent of their injuries. In the instant matter, the facts demonstrate that after Petitioner was declared to be at MMI she returned to her full-time position with respondent and continues to fully capable of performing her normal and customary job duties without restriction or impairment. Based on these facts, Petitioner's sole avenue of obtaining further compensation rests on whether she has supplied sufficient evidence to demonstrate that she suffers from Permanent Partial Disability.

When determining the level of permanent partial disability attributable to Petitioner's compensable injury – Petitioner's medial meniscal tear – section 8.1(b) of the Illinois Workers' Compensation Act dictates the Commission shall base its determination on the following five factors:

1. Petitioner's reported level of impairment pursuant to subsection (a);
2. Petitioner's occupation;
3. Petitioner's age at the time of the injury;
4. Petitioner's future earning capacity;
5. And, evidence of disability corroborated by the treating medical records.

The Act further provides that "[n]o 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."

Neither party submitted an impairment rating. Therefore, the Arbitrator assigns no weight to the first factor.

As for Petitioner's occupation, Petitioner returned to work without restrictions and experiences no difficulty with her current work duties. Petitioner suffered no change in position with her employer and provided no evidence of impairment of future employability or career progression. Petitioner's testimony evinced no specific work habits that might cause her discomfort and merely stated that on "hard" days has some symptomology. Petitioner's trial testimony is contradicted by Petitioner's treatment records wherein she indicated she was symptom free. While the Act does not indicate that evidence under this factor must necessarily be corroborated by the medical records, it is worth noting the totality of Petitioner's testimony regarding her disability, however small, contradicts the totality of that very disability as found in the medical records. In ***Sleeter v. Indus. Comm'n***, 346 Ill. App. 3d 781, 784, 805 N.E.2d 1227, 1229 (4th Dist. 2004), it was held that statements found in medical records contemporaneous with related treatment were more credible than conflicting trial statements. A similar result was reached in ***Hosteny v. Illinois Workers' Comp. Comm'n***, 397 Ill. App. 3d 665, 677, 928 N.E.2d 474, 484 (1st Dist. 2009). In ***Hostney***, the court noted, "[a]lthough an employee's testimony about an alleged accident might be sufficient, standing alone, to justify an award of benefits under the Act, it is not enough where consideration of all facts and circumstances demonstrate that the manifest weight of the evidence is against it. ***Id.***, ***citing Caterpillar Tractor Co. v. Industrial Comm'n***, 129 Ill.2d 52, 58, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). Based on this precedent, the Arbitrator affords greater weight to the evidence in the medical records that Petitioner was asymptomatic, and finds Petitioner's trial statements to lack similar credibility. Moreover, Petitioner offered no testimony indicating that she had to alter or cease her prior work habits. Similarly, Petitioner provided no testimony that required any assistance with completing her job duties since reaching MMI. Based on the forgoing, the Arbitrator finds no probative evidence of disability under this factor.

At the time of her Accident, Petitioner was 33 years of age. Based on the findings above and below, which indicate little disability, the Arbitrator finds little probative evidence of disability under this factor. One's age alone does not follow a linear scale when evaluating disability and must be evaluated

always inherently subjective, we must apply some objective descriptors so as to evaluate Petitioner's impairment and disability attributable to the injury in question. While such descriptors will not always be the most precise and will be lacking in a degree of credibility and persuasiveness (since they are ultimately used to describe something that is entirely subjective) they are the only means by which Petitioner's abilities and impairments may be defined and understood. In summation, Petitioner alleges that she sometimes suffers from pain after a hard day at work. Not only is this testimony uncorroborated in the medical records, but it also fails to differentiate itself from the pain any similar person would feel after a hard day at work. This testimony is too vague a basis on which to award permanency. Again "[l]iability under the Act cannot rest upon imagination, speculation or conjecture, but must be based solely upon the facts contained in the record." ***Cook County v. Indus. Comm'n***, 68 Ill. 2d 24, 30, 368 N.E.2d 1292, 1295 (1977) (*citing* ***Schroeder Iron Works v. Indus. Comm'n***, 36 Ill. 2d 519, 523, 224 N.E.2d 233, 236 (1967); ***A. O. Smith Corp. v. Indus. Comm'n***, 33 Ill. 2d 510, 513, 211 N.E.2d 749, 750 (1965). Moreover, Petitioner testified that, whatever her symptoms were, she had no issue discharging the duties of her employment. On this basis, the Arbitrator finds very little evidence of disability.

Based on the forgoing and having considered the totality of the evidence submitted at trial, the Arbitrator awards Petitioner permanent partial disability benefits commensurate with 10% loss of use of the person as a whole.

within the context of Petitioner's demonstrated physical impairments. In other words, whereas one person's young age may be seen as a factor that increases the disability determination, age may have little probative value in another determination where the facts of Petitioner's physical impairment interact differently with their line of work and anticipated future positions. In the instant matter, Petitioner's age has little probative value in determining permanent partial disability. Petitioner suffers from no impairment of occupation. Petitioner does not suffer from any impairment of income and does not appear to be poised to suffer from future advancements or employability as a result of her condition. Petitioner is young and does have current complaints of lingering symptomology. It may be proposed that, Petitioner, due to her young age, will have to suffer from the lingering symptomology she alleged at trial for a fairly prolonged period; however, Petitioner's complaints are not corroborated in the medical records. "Liability under the Act cannot rest upon imagination, speculation or conjecture, but must be based solely upon the facts contained in the record." ***Cook County v. Indus. Comm'n***, 68 Ill. 2d 24, 30, 368 N.E.2d 1292, 1295 (1977) (*citing* ***Schroeder Iron Works v. Indus. Comm'n***, 36 Ill. 2d 519, 523, 224 N.E.2d 233, 236 (1967); ***A. O. Smith Corp. v. Indus. Comm'n***, 33 Ill. 2d 510, 513, 211 N.E.2d 749, 750 (1965). In weighing the credibility of such evidence, the Illinois Workers' Compensation Commission generally holds that Petitioner's statements to medical providers carry greater weight, persuasiveness, and credibility versus conflicting statements the Petitioner offers at trial. *See* ***Teri Rule, Petitioner v. Cmty. Care Sys., Inc.***, Respondent, 12 IL. W.C. 1104 (Ill. Indus. Com'n Dec. 18, 2015); *see also* ***Dallas Allen, Petitioner v. Mr. Bult's, Inc., Respondent***, 02 IL. W.C. 6703 (Ill. Indus. Com'n Feb. 16, 2011); *see also* ***Jeff Edwards, Petitioner v. Cloverleaf Grain, LLC, Respondent***, 11 IL. W.C. 08355 (Ill. Indus. Com'n Apr. 24, 2013). In reconciling the conflicting evidence, the Arbitrator affords greater weight to the evidence of Petitioner's symptomology as found in the medical records as Petitioner offered no explanation as she may have reported her symptoms to her doctor and the commission differently. Based on the forgoing, the Arbitrator finds little to no probative evidence of disability under this factor.

Regarding Petitioner's future earning capacity, Petitioner has suffered from no limitations as a result of her compensable accident. Petitioner has returned to work without restrictions. The evidence submitted a trial demonstrates that Petitioner's current and future earning capacity is in no, way, shape, or form impaired as a result of her accident. On this basis, the Arbitrator finds no probative evidence of disability under this factor.

The evidence of Petitioner's disability as garnered from her testimony indicates that Petitioner has some mild symptomology attributable to her neck injury. However, Petitioner's final treatment records are devoid of such complaints. While Petitioner's testimonial complaints of pain could be conceived as being probative of impairment and disability attributable to the injury in question, these complaints stand uncorroborated in the medical records. Since section 8.1(b) demands that such evidence be corroborated in the treating medical records, Petitioner's testimony lacks the credibility demanded by the Act and cannot be considered for purposes of evaluating Petitioner's disability under this factor. On this basis the Arbitrator finds no evidence of disability under this factor.

Even if Petitioner corroborated her trial testimony with medical records, her testimony is still lacking in terms of specificity. Petitioner provided no specifics as to the degree of pain. Petitioner provided no specifics as to the frequency of occurrence of her neck pain. While complaints of pain are

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

Josefina Valdez,
Petitioner,

vs.

NO: 10 WC 34594
10 WC 34595
10 WC 34596

Creative Contract Packaging,
Respondent.

18IWCC0416

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 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.

JUL 2 - 2018

DATED:
o062818
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION
FEE PETITION

VALDEZ, JOSEPHINA
Employee/Petitioner

Case# **10WC034594**

10WC034595
10WC034596

CREATIVE CONTRACT PACKAGING
Employer/Respondent

18IWCC0416

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:

4220 LULAY LAW OFFICES
MICHAEL LULAY ESQ
2323 NAPERVILLE RD SUITE 220
NAPERVILLE, IL 60563

0247 HANNIGAN & BOTHA LTD
KEVIN S BOTHA
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

2986 PAUL A COGHLAN & ASSOC PC
15 SPINNING WHEEL RD
SUITE 100
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
FEE PETITION

JOSEPHINA VALDEZ
Employee/Petitioner

v.

CREATIVE CONTRACT PACKAGING
Employer/Respondent

Case # 10 WC 34594

Consolidated cases: 10 WC 34595 & 10 WC 34596

18IWCC0416

The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **ELGIN**, on **4-21-15**. 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 **FEE PETITION DISPUTE BETWEEN THE LAW FIRMS OF HANNIGAN & BOTHA & LULAY LAW.**

ORDER

- The Arbitrator finds that petitioning counsel, Hannigan & Botha, Ltd. is to receive $4,150.00 in attorney's fees because the Arbitrator finds that the 16.6 hours documented in their time record is a fair reflection of their time and labor spent on this case. Responding counsel Lulay Law Office is to receive the remaining $5,850.00 of the attorney's fees associated with the total settlement amount. The Arbitrator further orders the settlement proceeds which are held in escrow to be disbursed only upon a final decision in the event of a petition for review or further appeal.

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

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

3/10/16
Date

MAR 15 2016

STATE OF ILLINOIS)

)SS.

COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

ATTORNEY FEE PETITION DISPUTE

Josefina Valdez
Employee/Petitioner

Case # 10 WC 34594

v.

Consolidated cases: 10WC 34595 & 10WC 34596

Creative Contract Packaging, LLC.
Employer/Respondent

18IWCC0416

The petitioning party Hannigan & Botha, Ltd. filed a petition for attorney's fees pursuant to section 16 of the Act in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Elgin**, on **April 21, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes the following findings:

BACKGROUND

Three cases are before the Arbitrator for resolution of a fee dispute between the law firms of Hannigan & Botha, Ltd. and Lulay Law offices. Both firms represented the Petitioner Josefina Valdez as a result of three alleged injuries on September 13, 2007 November 9, 2009 and July 21, 2010.

On September 3, 2010, the Petitioner retained Kevin Botha of Hannigan & Botha, Ltd., and signed an Attorney Representation Agreement and Applications for Adjustment of Claim for each of the three claimed injuries. On September 10, 2010 Mr. Botha filed the three separate Applications for Adjustment of Claim at the Illinois Worker's Compensation Commission as companion cases (See Lulay Px.1, Px.9 and Px.10).

On March 8, 2011 Kevin Botha received a Stipulation to Substitute Attorney from Michael Lulay with correspondence explaining that Kevin Botha was being discharged as the Petitioner's attorney.

On November 7, 2011, Kevin Botha prepared a Petition for Attorney's Fees seeking $4,150.00 based upon quantum meruit for 16.6 hours he spent working on all three cases. The fee petition was presented to Arbitrator Kinnaman on December 6, 2011, and the Arbitrator entered an order that the attorney fee petition would be continued until case resolution (Hannigan & Botha Px.1).

Mr. Lulay contacted Mr. Botha in early 2015 and advised him that the case had tentatively been settled for $50,000.00. Based upon the contingency fee agreement of 20%, there were attorney's fees in the amount of $10,000.00. The parties could not reach an agreement as to the division of the attorney's fees.

On April 21, 2015 Arbitrator Hegarty approved the settlement contracts resolving all the cases for $50,000. The dispute regarding attorney's fees did not resolve, and the matter went to hearing on the same date.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator notes that the Petitioner Josefina Valdez was not available for testimony during the hearing on the fee petition.

Mr. Paul Coghlan testified that he has been an attorney in Illinois for 24 years and practiced Worker's Compensation law. He represents both Respondents and Petitioners in Worker's Compensation disputes (Tr.5-6). Mr. Coghlan represented Creative Contract Packaging, the Respondent in these cases. Mr. Coghlan reviewed Hannigan & Botha's attorney's fee petition and testified that he would not dispute any of the time spent between him and Kevin Botha during Mr. Botha's representation of the Petitioner (Tr.9) and again on cross examination (Tr. 33). Mr. Coghlan further testified that when the fee petition first came in he looked at it and thought that it looked reasonable based upon his experience. (Tr. 34-35).

Mr. Coghlan testified that he requested the evidence deposition of Dr. Johnston at Dreyer Medical Clinic because of the lack of any history relative to her back injury contained in his records despite a few visits the Petitioner had with Dr. Johnston (Tr. 12). Mr. Coghlan testified that at that point in time the compensability of the shoulder claim had been accepted (Id.). The evidence deposition of Dr. William Johnston was entered into evidence as Hannigan & Botha Exhibit 2. After Mr. Coghlan completed his direct examination regarding any treatment or history of injury to the Petitioners lower back, Mr. Lulay then questioned Dr. Johnston as to causation issues regarding the Petitioners left shoulder. Mr. Coghlan testified that the doctor eventually opined that the surgery was not related to the alleged work accident. Following the deposition of Dr. Johnston, the left shoulder injuries were disputed (Tr. 13). Mr. Coghlan then used Dr. Johnston's deposition transcript to obtain a causal connection opinion regarding the shoulder injury from the treating orthopedic surgeon, Dr. Szuch, and based upon Dr. Johnston's testimony she could not render an opinion that Petitioner's condition and was causally connected to her alleged injuries (Tr. 12; See also Hannigan & Botha Px.3 and Px.4).

Dr. Szuch's evidence deposition was highly adversarial. Mr. Coghlan had several issues with Mr. Lulay's speaking objections during the evidence deposition to the point where the deposition ended abruptly.

The second evidence deposition of Dr. Szuch was completed on June 29, 2013 and Mr. Lulay failed to appear (H&B Px.4). Mr. Coghlan testified that after the depositions were completed, in his estimation, the value of the case went down and that the treating physician testified that the surgery was not related was a substantial factor (Tr.23-24).

Upon cross examination, Mr. Lulay asked Mr. Coghlan how he would characterize his feelings towards Mr. Lulay personally (Tr. 25). Mr. Coghlan responded that he did not know him well enough to like or dislike him. Mr. Coghlan testified that because of Mr. Lulay's behavior during Dr. Szuch's first evidence deposition, which ended abruptly, because in Mr. Coghlan's opinion, Mr. Lulay's conduct crossed the line of attorneys conducting evidence depositions, the attorneys then spent the next 6 or 7 months going back and forth in resetting the deposition (Tr. 68). Mr. Coghlan testified that "nothing happened on the case for 8 months because you decided to start prefacing all of your questions just like you're doing with me here this morning with the doctor. You started giving information to the doctor before you ask a question. You can't do that." (Tr. 69). Mr. Coghlan testified that the dialogue between him and Mr. Lulay at the time of the hearing on the instant matter was indicative of the way the case went when he was handling it (Tr. 79).

Kevin Botha testified on his own behalf that he is a licensed attorney in the state of Illinois and practices Worker's Compensation law exclusively. He is a member of the Board of Directors of the Worker's Compensation Lawyers Association and has published several articles on Worker's Compensation issues (Tr. 81-82). Mr. Botha testified that the procedure when a new client is signed up involves a meeting with the attorney and an intake form is reviewed but is usually incomplete or needs to be fully investigated. Sometimes this could be half an hour or could take a lot longer.

He testified that in this case there were 3 different injuries and repetitive trauma cases (Tr. 83-84). Mr. Botha testified that the attachment to the fee petition included a time sheet which recorded his time spent on this case. He testified that he does not record time spent per event or record their hours, instead of timesheets and time records there is a record of every contact, phone call, every detail of work that was done on the file. He described the note system and how a phone call would then be recorded in the chronology, what the conversation was about and what advice was given to the client. There is a copy of correspondence kept which gets recorded in the notes section and also a physical copy to keep in the hard file. He described the work involved when medical records are received in the office. An attorney would review the medical records and then they are recorded in a specific medical chronology. The doctor's name would be entered, the Petitioner's work status would be entered and the nature of each and every visit would be recorded in the medical chronology (Tr. 87). He testified that he was able to look at the notes and determine the amount of time spent on the file by reviewing those notes and that this was in an accurate reflection of the time spent on this case which was attached to the Petitioners fee petition (Px.1). He testified that his partner Richard Hannigan did a review of some of the medical records from Dreyer Clinic since he was out of the country at the time (Tr. 88).

Mr. Botha testified that all 3 claims were filed and initially the Petitioner's complaints at the time were regarding her back. With respect to the shoulder, she was receiving treatment and surgery was scheduled and there weren't any issues with regards to the shoulder claim (Tr. 89). He also testified that he filed an immediate 19(b) when the applications for adjustment of claim were filed in an attempt to get the Petitioners treatment going as quickly as possible (Tr. 89). He testified that the back claim was denied initially because none of the medical records contained any history of the Petitioner injuring her back (Tr. 90). He testified that Respondent was going to schedule an IME with Dr. Matz, and that in his experience Dr. Matz never rendered an opinion in favor of the Petitioner and lacks credibility (Tr. 90). Mr. Botha testified that he had a conversation with Mr. Coghlan that any evaluation by Dr. Matz is not going to help either party, merely create more issues. The parties then agreed upon using Dr. Alexander Ghanayem at Loyola for the section 12 examination which was scheduled for January 7, 2011 (Tr. 90-91). The Petitioner attended the evaluation and Mr. Botha was awaiting the IME report before proceeding but was terminated in early March 2011 (Tr. 91). Mr. Botha testified that Exhibit #5 contained copies of the checks included with subpoenas that are sent to medical providers requesting records (Tr. 92) and the medical records were sent to Mr. Lulay, and Mr. Lulay did not reimburse Hannigan & Botha, Ltd. for said expenses (Tr. 92-93). Again he testified that the hours contained in the fee petition were an accurate representation of the time spent on this case, further Mr. Botha testified that was a conservative estimation of the time spent on the file since periodic reviews between the attorneys were not included in the time record (Tr. 97).

Upon cross-examination Mr. Botha was given Mr. Lulay's group exhibit #80 which were selected portions of the Hannigan & Botha, Ltd firms file (Tr. 98). Mr. Botha testified that neither he nor Mr. Hannigan spoke Spanish and communicated with the Petitioner through their bilingual Spanish/English paralegal, Aroselli Jimenez and that Ms. Jiminez is currently employed at the firm (Tr. 100). Mr. Botha testified that if there was a simple matter of a client not receiving a TTD check then Ms. Jiminez would contact the adjuster or attorney to find out the reason and then later inform the client, and then he would not be involved in that conversation. However if there was a legal dispute or an issue that an attorney had to get involved with then Ms. Jiminez would bring the issue to Mr. Botha and he would address it do

what was necessary and inform Ms. Jiminez to inform the client (Tr. 101). Mr. Botha testified that the substance of phone calls would be recorded in the notes which were submitted into evidence as H&B Px.7. Mr. Botha testified that the time listed in his fee petition was for his own personal attorney time and not for any administrative staff (Tr. 109-110). Mr. Lulay questioned Mr. Botha on cross-examination as to every letter and every subpoena issued as well every phone call made or received. Mr. Botha filed an immediate 19(b) petition, and the case was set for hearing on November 16, 2010 off the November 3, 2010 call date (Tr. 182).

Mr. Botha testified that the evidence deposition of Dr. Johnston set for April 26, 2011 and was confirmed by Mr. Coghlan's office on March 3, 2011 via telephone and March 5, 2011 in writing. He testified that he convinced Mr. Coghlan to use Dr. Ghanayem over Dr. Matz for an IME because of credibility issues. (Tr. 190-191).

In this case, as in every case, Petitioning counsel is entitled to be paid reasonable fees for services rendered to a Petitioner before discharge. The Illinois Appellate Court in *Wegner v. Arnold*, (1999), 305 Ill.App.3d 689, 713 N.E.2d 247, 238 Ill.Dec. 1001 specifically held that "A discharged attorney is entitled to be paid on a quantum meruit basis a reasonable fee for services rendered before discharge." The court in *Wegner* has set forth several factors to be used in making a quantum meruit determination. These factors include:

1) the time and labor required;
2) the attorney's skill and training;
3) the nature of the cause;
4) the novelty and difficulty of the subject matter;
5) the attorney's degree of responsibility in managing the case;
6) the usual and customary charge for that type of work in the community and;
7) the benefits resulting to the client.

In analyzing these factors, the Arbitrator has reviewed the file documentation produced at the hearing as well as the time itemizations offered by Kevin Botha. The case remained with Hannigan & Botha from September 2010 through March 8, 2011, a period of about 7 months. The case was with Lulay law offices counsel from March 2011 through the settlement in April 2015, a period of approximately 4 years. Mr. Coghlan testified that Mr. Lulay's conduct in the evidence deposition was unprofessional and that because of Mr. Lulay's actions the next 6 to 7 months were only spent on rescheduling the deposition. Mr. Coughlan testified that the dialog between him and Mr. Lulay at the time of this fee petition hearing was indicative of the way the case went when he was handling it. The Arbitrator observed Mr. Lulay's argumentative questions as well as responses on both direct exam, cross exam, and as a witness.

The Arbitrator notes this fee Petitioner hearing lasted approximately 5 hours.

The Arbitrator finds that the length of time that each firm represented the Petitioner in this case is not a fair reflection of the efficient amount of time each party spent on this case. In the instant case, the Arbitrator finds that Hannigan and Botha performed a considerable amount of work during the 7 months of their representation of the Petitioner. They prepared and filed 3 applications for adjustments of claim on behalf of the Petitioner together with an immediate 19(b) petition. The 19(b) petition was set for hearing on November 16, 2010 however was continued because the Respondent scheduled the Petitioner for a Section 12 examination with Dr. Matz. Mr. Botha convinced Mr. Coghlan to have Dr. Ghanayem examine the Petitioner due to credibility issues. The Arbitrator notes the issues surrounding this case with regards to causal connection. The Arbitrator finds that Mr. Botha spent considerable time and labor in reviewing medical records, communicating with the Petitioner though Ms. Jimenez and getting the

Petitioner to see reputable doctors to allow her to obtain the necessary medical treatment. While there is no indication of settlement negotiations prior to Mr. Lulay's involvement, Mr. Botha's representation of the Petitioner provided a solid groundwork which ultimately resulted in benefits to the Petitioner. The Arbitrator finds the applicable attorneys' fee rate is $250.00 per hour based on the testimony by Mr. Coghlan and after he had reviewed the fee petition, and testified that he would not dispute any of the time spent between him and Mr. Botha and that he felt it looked reasonable based upon his own experience in quantum meruit cases which he had been doing for 23 or 24 years and that many times he can tell from looking at something whether it looks reasonable or not. Mr. Botha testified that the time sheet attached to the fee petition in H&B Px.1 was an accurate representation of the time spent on the case based upon the firm's record keeping system and Mr. Botha's testimony.

Consequently, based on all of the above, the Arbitrator finds that petitioning counsel, Hannigan & Botha, Ltd. is to receive $4,150.00 in attorney's fees because the Arbitrator finds that the 16.6 hours documented in their time record is a fair reflection of their time and labor spent on this case. Responding counsel Lulay Law Office is to receive the remaining $5,850.00 of the attorney's fees associated with the total settlement amount. The Arbitrator further orders the settlement proceeds which are held in escrow to be disbursed only upon a final decision in the event of a petition for review or further appeal.

ORDER

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

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

Jason C. Hyatt

Signature of Arbitrator

3/10/16
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Greg Daley,

Petitioner,

vs. NO: 15WC 14867

Hall Enterprises, Inc., Insurance Company of the West ,

18IWCC0417

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 expenses, prospective medical, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 19, 2017, is hereby affirmed and adopted.

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

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: JUL 2 - 2018

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LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

DALEY, GREG
Employee/Petitioner

Case# **15WC014867**

HALL ENTERPRISES INC INSURANCE COMPANY OF THE WEST
Employer/Respondent

18IWCC0417

On 6/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1876 CZAPLA LAW
EDARD ADAM CZAPLA
1821 WALDEN OFFIE SQ #400
SCHAUMBURG, IL 60173

0210 GANAN & SHAPIRO PC
BENJAMIN W SCHROEDER
210 W ILLINOIS ST
CHICAGO, IL 60654

18IWCC0417

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)

GREG DALEY
Employee/Petitioner
v.
HALL ENTERPRISES, INC., INSURANCE COMPANY OF THE WEST
Employer/Respondent

Case # 15 WC 014867

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **5/12/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **3/9/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$104,000.00**; the average weekly wage was **$2,000.00**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$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 sustained a left eye injury which is causally related to his work injury of March 9, 2015.

Respondent shall pay all the reasonable and necessary medical services outlined in Petitioner's Exhibit No. 4, as provided in Section 8(a) and 8.2 of the Act, and subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid and Respondent shall hold Petitioner harmless for any claims by any providers for services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay for the PTK laser surgery and necessary follow up treatment pursuant to Section 8(a) and 8.2 of the Act, and subject to the fee schedule.

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

Respondent shall pay Petitioner compensation that has accrued from March 9, 2015 through May 12, 2017 and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

6/19/2017
Date

JUN 19 2017

FINDINGS OF FACT

The parties stipulated that Respondent, Hall Enterprises, was operating under the Illinois Workers' Compensation Act on March 9, 2015. The parties also stipulate that Petitioner, Greg Daley, sustained an accidental injury that arose out of and in the course of his employment by Respondent on March 9, 2015 and notice of the accident, within the time limits stated in the Act, was given to Respondent. Respondent denies Petitioner's current condition of ill-being is causally connected to the instant injury and Respondent denies being liable for certain unpaid medical bills. Petitioner is seeking prospective medical treatment which Respondent disputes.

Petitioner is a 52-year-old automobile technician who sustained an injury to his left eye on March 9, 2015. Petitioner testified he was injured working on a vehicle looking for an oil leak. The oil leak was underneath the engine on the driver's side of the vehicle. Petitioner was lying on top of the engine, using mirrors to locate the oil leak, when he took his safety glasses off and stuck his head down between the engine and the firewall. When pulling his head up, Petitioner poked his left eye on a plastic tie strip used to secure hoses and wiring harnesses to the firewall. Petitioner immediately stopped working and flushed his eye out with water and reported his injury. (TR. 14, 15, 16)

Petitioner testified immediately after poking his left eye he was experiencing swelling and burning sensation in his left. Petitioner returned to work and completed his shift. That night Petitioner's eye felt sore and was swollen and he was experiencing a burning feeling. Petitioner applied hot compresses to his eye and took the following day off work. (TR. 17, 21) Petitioner testified since his work injury he continues to experience problems with his vision. Petitioner testified prior to his March 9, 2015 he not experienced any vision problems or sought medical treatment for his left eye. (TR 23)

On March 17, 2015, Petitioner was examined by Dr. Robert Mack of Mack Eye Center. Petitioner went to see Dr. Mack because he did not believe his eye was healing and he was still experiencing problems with his vision. (TR. 22, 25) The medical records show Petitioner was complaining of decreased visual acuity in the left eye with a glare, swelling, burning, redness, pain and a foreign sensation in the left eye. (PX.3) After the examination, which included corneal topography, Dr. Mack's findings consisted

of: Lattice corneal dystrophy, trace cataracts, other anterior corneal dystrophies, Terrien's marginal degeneratior, foreign body in cornea and superficial injury of the cornea. (PX 3) Dr. Mack recommended phototherapeutic keratectomy (PTK) eye surgery.

It is undisputed that Petitioner suffered from an underlying condition called basement membrane dystrophy in both eyes. It is also undisputed that Petitioner had previously suffered a cornea abrasion injury to his right yet successfully treated with the PTK procedure in 2007. The right eye cornea abrasion injury occurred when Petitioner was poked in the right eye while pulling a hard piece of plastic in the bask seat of a car at work. (PX 3) The injury to his right eye (09 WC 35202) as settled on April 16, 2010. (RX 6)

Pursuant to Section 12 of the Act, Petitioner was examined by Dr. Carrie Golden-Brenner on June 8, 2015. Dr. Golden-Brenner was deposed on two occasions (November 5, 2015 and February 3, 2016). Dr. Golden-Brenner was deposed a second time because she was provided additional medical records to examine. (RX 4) At the second deposition, Dr. Golden-Brenner acknowledged she did not have a formal cornea fellowship but she worked in a practice which was managed by a former full professor and director of cornea fellowship at the University of Iowa and the University of Witswateraand. (RX 4) Dr. Golden-Brenner did not believe Petitioner's condition was caused by the Petitioner's work injury of March 9, 2015. Dr. Golden-Brenner testified had Petitioner sustained an abrasion to his cornea on March 9, 2015 it was mild and had healed by the time he was seen by Dr. Mack on March 17, 2015. (RX 4, pg. 32) Dr. Golden-Brenner testified Dr. Mack's records which, she states, doesn't document any foreign body or removal of a foreign body. (RX 4, pgs. 47, 56) Dr. Golden-Brenner 's opinions were based upon her review of the medical records, which she said did not contain a finding of an acute injury during the March 17th examination, and the fact that Petitioner was only off work for one day and that Petitioner has 20/20 vision in each eye with corrective lenses. (RX, pg. 22) Dr. Golden-Brenner acknowledges a significant trauma could aggravate a preexisting corneal basement membrane dystrophy. (RX 4, pg. 49)

Petitioner returned to Dr. Mack on August 20, 2015. At that time, Petitioner was complaining of blurry vision, itching and more tearing. Dr. Mack performed ophthalmoscopic slit lamp examinations and corneal topography. Dr. Mack's records state the slit lamp photos

show a clear and bothersome reduplication of the corneal epithellum centrally OS, following a corneal abrasion. Regarding the existence of the corneal abrasion and need for the PTK procedure upon and the underlying condition of anterior basement membrane dystrophy, Dr. Mack wrote:

> *"this was not present at the time of his PTK" for his other eye..this coincided with the injury. Patient with pre-existing epithelia basement membrane dystrophy often have pain and blur after traumatic corneal abrasions and the corneal abrasion was documented in this case. This is an open and shut case of abrasion resulting in a very bothersome visual irregularity...I need to respectfully pull rank on Dr. Golden Brenner and insist corneal specialist review. The slit lamp photos taken today really show it all."* (PX 3)

Petitioner was last seen by Dr. Mack on January 14, 2016 (PX.3) Petitioner testified he would like to proceed with the PTK procedure. He still has blurriness in his left eye and the blurriness is in the center of his eye right in his line of vision. Petitioner testified his vision is blurry in the center of his eye, in his line of vision, and his eye is not blurry if he looks to the left or right. Petitioner said if he turns his head to the left or right, he can see better. (TR., pg. 30) Petitioner testified his vision problems causes him problems at work because he can't see correctly and he also has problems with depth perception. Since his work accident, Petitioner needs to use a monocle and flashlight to perform some of his work duties which he did not need to use prior to his injury. (TR. pg. 31)

The Arbitrator found the testimony of Petitioner to be credible.

CONCLUSIONS OF LAW

The employee bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 867 (2010). Among the elements that the employee must establish is that his condition of ill-being is causally connected to his employment. *Elgin Board of Education U-46 v. Workers' Compensation Comm'n*, 409 Ill. App. 3d 943, 948 (2011). Thus, if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro supra.* "[*A*] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd dist. 2000). Proof of an employee's state of good health prior to the time of injury, and the

change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976). It is well established that an accident need not be the sole or primary cause as long as employment is a cause of a claimants' condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 205 (2003). An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where the employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36 (1982).

WITH RESPECT TO ISSUE (F) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CASUALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes Petitioner has proven by a preponderance of the credible evidence he sustained a left eye injury which is causally related to his work injury as set forth more fully below. It is undisputed that Petitioner injured his left eye at work on the afternoon of March 9, 2015 when he was poked in the eye by a plastic tie strap and Petitioner has a pre-existing condition in both eyes known as basement membrane dystrophy. It is also undisputed that Petitioner did not experience problems or receive any medical treatment to his left eye prior to accidental injury of March 9, 2015.

Immediately after the injuring his left eye, Petitioner stopped working, flushed out his eye with water and reported the accident. Overnight Petitioner developed swelling, soreness and blurred vision. Petitioner did not return to work the following day. Petitioner's left eye symptoms did not improve so he sought medical treatment with Dr. Mack on March 17, 2015. At that time, Petitioner had developed a glare in the left eye along with burning, swelling, soreness and pain. Petitioner described the feeling of having a foreign body in the left eye and decreased visual acuity. (PX.3)

Dr. Golden-Brenner testified Petitioner did not sustain a trauma or Petitioner sustained a sight trauma which resolved by the time Petitioner saw Dr. Mack because Dr. Mack's records did not document the existence or removal of a foreign body from Petitioner's eye. The

Arbitrator finds Dr. Golden-Brenner's opinions are not persuasive. Dr. Golden-Brenner's opinions fail to acknowledge the possibility a corneal abrasion could exist without a foreign body remaining in the eye and Dr. Golden-Brenner's opinions also fail to accept Dr. Mack's actual findings. Dr. Golden-Brenner opinion appears to be based upon what was not in the medial records rather than what was in the medical opinion or speculation. Dr. Golden-Brenner did not offer any testimony regarding the appropriate standard of care for documentation and whether Dr. Mack breached that standard of care. Dr. Mack found a corneal abrasion. Additionally, not every corneal abrasion leaves a foreign body. In this case, the abrasion was caused by a plastic tie and, it appears unlikely, based upon the object which caused the abrasion, part of the plastic tie would have broken off and remained in Petitioner's eye. Dr. Golden-Brenner opinion does not address the possibility that had a foreign body existed could it had been removed when Petitioner washed out his eye with water immediately after sustaining the injury.

Dr. Mack's examination found that Petitioner sustained a corneal abrasion which was caused by trauma. Dr. Mack said the corneal abrasion, which he found during his examination, did not exist in 2007 when Dr. Mack examined Petitioner's left eye as part of the treatment for the Petitioner's right eye injury. Regarding the causal relationship between Petitioner's accident of March 9, 2015 and the corneal abrasion and need for laser surgery, Mr. Mack wrote: "*...show clear and bothersome reduplication of the corneal epithellum centrally os, (left eye) following a corneal abrasion. This was not present at the time of his PTK, post trauma, of the other eye. This coincided with the injury. Patients with pre-existing epithelial basement membrane dystrophy often have pain and blur after traumatic corneal abrasions, and a corneal abrasion was documented in this case. This is an open and shut case of abrasion resulting in very bothersome visual irregularity... The slit lamp photos taken today really show it all.*" (PX.3)

The Arbitrator finds the opinions of Dr. Mack to be more persuasive than those of Dr. Golden-Brenner. The Arbitrator notes from Dr. Mack's *Curriculum Vitae* that he is a board-certified Ophthalmologist and cornea specialist having completed a fellowship in Cornea, Anterior Segment, and Refractive Surgery. (PX.3) Dr. Golden-Brenner is not a cornea specialist and she does not perform PTK laser eye surgery (RX.2 p.29, RX.4 p.6)

The Arbitrator significant that prior to March 9, 2015 Petitioner was not experiencing vision problems nor sought treatment for his left eye. Petitioner testified he

could see correctly before the injury at work and did not need corrective eyewear. The Arbitrator finds a temporal relationship between the trauma to the left eye and the immediate onset of symptoms. Following the trauma Petitioner experienced blurred vision, swelling and left eye pain. Petitioner testified he experiences blurriness is in the center of his eye right, in his line of vision, and he doesn't experience blurriness on the right or left side of his eye. The Blurriness is in the center of his eye, the area of the corneal abrasion. To this point, Dr. Golden-Brenner testified "*that if the plastic caused a corneal abrasion, it is possible that he might have a little bit of Basement Membrane changes in that location only*". (RX.2 p.63)

Therefore, based upon the credible medical evidence along with Petitioner's uncontradicted testimony, the Arbitrator finds that Petitioner's left eye injury is causally related to the March 9, 2015, accident at work.

WITH RESPECT TO ISSUE (J) WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator concludes Petitioner has proven by a preponderance of the evidence that the medial service provided by Dr. Mack of Mack Eye Center for the dates of service of August 20, 2015, November 19, 2015 and January 14, 2015 were reasonably required to diagnose, treat, cure and relieve Petitioner from the effects of his injury and the services are causally related to his work injury. Respondent shall pay all the reasonable and necessary medical services outlined in Petitioner's Exhibit No. 4, as provided in Section 8(a) and 8.2 of the Act, and subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid and Respondent shall hold Petitioner harmless for any claims by any providers for services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

WITH RESPECT TO ISSUE (K) IS PETITIONER ENTITLED TO ANY PROSEPCTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator concludes Petitioner has proven by a preponderance of the evidence that he is entitled to the prospective PTK laser surgery to the left eye ass recommended by Dr. Mack.

Respondent shall pay for the PTK laser surgery and related treatment pursuant to Section 8(a) and 8.2 of the Act, and subject to the fee schedule.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONALD STURM,

Petitioner,

vs.

NO: 14 WC 28015

CITY OF CHICAGO,

Respondent.

18IWCC0418

DECISION AND OPINION ON REVIEW

Petitioner timely filed a Petition for Review of the Decision of the Arbitrator. The Arbitrator found Petitioner's condition of ill-being remains causally related to his undisputed work accident. Regarding the benefits at issue, the Arbitrator found Petitioner failed to prove entitlement to wage differential benefits and instead awarded permanent partial disability under Section 8(d)2. The Arbitrator further found Petitioner failed to cooperate with vocational rehabilitation, was therefore not entitled to any maintenance benefits, and Respondent was granted a credit of $39,345.84 for maintenance benefits paid. Notice having been given to all parties, the Commission, after considering the issues of temporary disability, permanent disability, and credit, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission strikes the last sentence of the first paragraph on page 4 of the Arbitrator's Decision.

Supplemental Findings of Fact

As the vocational evidence is critical to our analysis of the issues on Review, the Commission provides a detailed recitation of those facts.

On June 14, 2016, Dr. Fernandez evaluated Petitioner for a final time. Memorializing Petitioner had residual pain, stiffness, weakness, and loss of motion, Dr. Fernandez placed Petitioner at maximum medical improvement and, based on the objective losses and the nature of the partial fusion, concluded Petitioner is permanently restricted to light duty activities in the 10-pound range on average with regards to gripping, pushing, pulling, use of tools, or use of machines, with additional restrictions on significant repetition or loading and extension and flexion across the wrist. PX1.

Petitioner testified he attempted to return to work with Respondent but was told the City could not accommodate him. T. 24. On June 20, 2016, Petitioner commenced a job search. T. 24. He stated, "I was looking for something where I didn't have to really use my left hand that much, anything that had to be heavy, counter work type of things." T. 24. He completed at least 10 inquiries per week. On cross-examination, Petitioner confirmed his testimony he applied for jobs he felt were within his restrictions such as jobs which did not require heavy lifting with his left wrist. T. 34-35. He agreed many of the jobs he applied for were stock help. T. 35. Asked if stock help would be moving things around in a stockroom, he stated he did not know as he never performed such a job. T. 36. Petitioner offered into evidence job search logs as Petitioner's Exhibit 6; this exhibit demonstrates Petitioner continued his self-directed job search through January 13, 2017. PX6.

While Petitioner was engaged in his self-directed job search, Respondent also enrolled him in vocational services with Vocamotive. A July 11, 2016 letter from Sharon Zajac of Vocamotive to Petitioner's Counsel evidenced Petitioner was referred by City of Chicago for vocational services. Ms. Zajac requested permission to contact Petitioner to arrange the initial assessment. PX7.

On September 6, 2016, a rehabilitation plan was prepared by Vocamotive's Kari Stafseth, CRC, who concluded vocational rehabilitation services were necessary. The report details Dr. Fernandez's restrictions and identifies tentative job targets of Front Desk Representative, Customer Service Representative, Concierge, and other occupations as appropriate; the wages projection was $10.00 to $12.00 per hour. The rehabilitation plan called for keyboard training to begin immediately upon the commencement of vocational services; vocational testing within the first 30 days; job seeking skills instruction to begin within the first 30 days; and job search activity targeted to begin approximately eight weeks after the start of the program. PX7. The Commission observes the plan was crafted prior to Ms. Stafseth having met with Petitioner.

The October 30, 2016 progress report, co-authored by Ms. Zajac and Ms. Stafseth, indicates vocational services were authorized on September 30 and Ms. Stafseth initially met with Petitioner on October 4, 2016. Ms. Stafseth documented Petitioner arrived early, was very polite and invested in the process. The report further reflects that for the remainder of the month, Petitioner continued with computer training and keyboarding; additionally, Petitioner underwent vocational testing on October 12, 2016. In the October 30, 2016 Rehabilitation Plan, Ms. Stafseth indicated no vocational counseling or behavioral self-management issues existed. PX7.

On November 10, 2016, James Boyd submitted his report from Petitioner's vocational testing. Mr. Boyd memorialized Petitioner was 58 years old, did not attend high school but

obtained a GED in 1983, and had worked as a journeyman bricklayer since 1986. Upon analyzing Petitioner's performance on a number of intelligence, aptitude, and dexterity tests, Mr. Boyd concluded Petitioner's aptitude and achievement levels were compatible with the following occupations: management trainee, personnel scheduler, project manager, project estimator, customer order clerk, service dispatcher, procurement clerk, warehouse checker, billing clerk, surveillance system monitor, repair order clerk, service order expediter, and information clerk. Mr. Boyd noted the list was representative, and not all-inclusive, of vocational options from a skills perspective and was based on medical opinion regarding Petitioner's work release and restrictions. PX7.

Petitioner was questioned about the assessment with Mr. Boyd. He agreed he advised Mr. Boyd his job included arranging labor, organizing tools, and some administrative tasks; Petitioner characterized his part in accomplishing those tasks as making a phone call. T. 37. Petitioner also agreed Mr. Boyd found he would be a candidate for administrative positions like personnel scheduler, project manager, project administrator, service dispatcher, and billing clerk. T. 38. Asked if it was fair to say he had more experience in administrative duties than an average laborer, Petitioner reiterated his experience in administrative duties was nothing more than making phone calls. T. 38.

The November 29, 2016 progress report demonstrates Petitioner continued with computer training, having completed Word Fast Track and begun Word Basic, as well as keyboarding, and had completed all four sessions of the Job Search Workshops. The report reflects Petitioner was asked about completing ADA paperwork to submit to Respondent, and Petitioner advised he had a discussion with the Water Department Head of Personnel and his understanding was his restrictions could not be accommodated; Petitioner further reported he would not be completing the ADA paperwork. Ms. Zajac and Ms. Stafseth noted Petitioner's vocational testing results were received and reviewed with him. It was also noted Petitioner "inquired about his age being a factor with regards to employment. He was advised that this was a factor taken into consideration. He reported his age was considered to be a negative factor"; Petitioner was assured he would be provided with all the tools and resources needed to assist him with returning to work. Ms. Zajac and Ms. Stafseth concluded the report by stating Petitioner "is diligent in his work and has been cooperative in all aspects of training." In the November 29, 2016 Rehabilitation Plan, Ms. Stafseth identified the same job targets: Front Desk Representative, Customer Service Representative, Concierge, and other occupations as appropriate; the projected wages also remained unchanged: $10.00 to $12.00 per hour. Ms. Stafseth again documented the absence of any vocational counseling or behavioral self-management issues. PX7.

At trial, Petitioner was asked if he recalled telling Vocamotive that he did not complete the Reasonable Accommodation Form. Petitioner responded, "Oh, that ADA thing? I have a disabled daughter. I'm not going to say that I'm disabled. I'm injured. That's it." T. 34.

The next progress report, dated January 2, 2017, evidences Petitioner remained in keyboarding and computer training; he completed Internet Basics and the Windows 7 curriculum and progressed to Microsoft Office 2013. The job targets and projected wages noted in the January 2, 2017 Rehabilitation Plan were unchanged. Ms. Stafseth indicated Petitioner had no vocational counseling or behavioral self-management issues. PX7.

In the February 5, 2017 progress report, Ms. Zajac and Ms. Stafseth recorded Petitioner continued with computer training and remained in the Word Basic curriculum. The report memorializes Petitioner should have completed computer training on January 10, 2017, but he still needed to complete a chapter of Word, complete the testing, and email training before moving to fulltime job search. The report reflects the reason Petitioner continued to struggle with computer training was unknown, given his vocational testing results, however he had increased his hours at Vocamotive to obtain additional assistance. The February 5, 2017 Rehabilitation Plan includes an expanded job target list: Front Desk Representative, Customer Service Representative, Concierge, Customer Order Clerk, Service Dispatcher, Procurement Clerk, Warehouse Checker, Billing Clerk, Surveillance System Monitor, Repair Order Clerk, Service Order Expediter, Information Clerk, and other occupations as appropriate. The projected wages, however, remained the same: $10.00 to $12.00 per hour. In the section regarding vocational counseling and behavioral self-management issues, Ms. Stafseth noted, "Mr. Sturm has fallen behind in computer training and has increased his hours at this office." PX7.

The March 6, 2017 progress report indicates Petitioner had completed computer training and transitioned to fulltime job search, further documenting Petitioner "has been completing all of his itinerary items" and "has been fully engaged in job search at this time." It was noted Petitioner "completed his cover letters without first checking to ensure that the job lead is still available and therefore; from time to time is running into the issue of not being able to complete the online application"; Petitioner was advised to send his letter directly to the employer even if the lead is not posted any longer. Ms. Zajac and Ms. Stafseth concluded, "While he works slowly, he is very careful about the work he does and he does not make errors." The March 6, 2017 Rehabilitation Plan identifies the same job targets and projected wages; it further indicates vocational counseling and behavioral self-management issues are absent. PX7.

Petitioner testified he is still enrolled at Vocamotive, and he last met with the Vocamotive counselor the week prior to trial. T. 26, 42. The job leads he receives from Vocamotive are similar to those identified in his self-directed job search: "counter-type thing, like desk clerk for like a motel. Most of it was concierge work." T. 27. He described a typical week:

> They give me an itinerary, and it's where I apply for jobs on a computer; and then I do follow-up calls to call the people to find out - - Most of the time, they just send an email back saying no, thank you, I don't fit what they want; and I went to - - I've had to go to places with my resume in my hand that they prepared for me and hand them out. They sent me. T. 28.

Petitioner has not found a job nor has he had any interviews. T. 27. Asked if he wants to return to the job force, Petitioner responded, "Absolutely. I have to." T. 27.

Conclusions of Law

I. Maintenance Benefits

Section 8(a) of the Act grants maintenance benefits while a claimant is engaged in a vocational rehabilitation program. *Greaney v. Industrial Commission*, 358 Ill. App. 3d 1002, 1019, 832 N.E.2d 331 (2005). A claimant's self-initiated and self-directed job search or vocational training may constitute a "vocational-rehabilitative program" under section 8(a). *Roper Contracting v. Industrial Commission*, 349 Ill. App. 3d 500, 506, 812 N.E.2d 65 (2004). Concluding Petitioner failed to put forth a good faith vocational effort, the Arbitrator denied all maintenance benefits. The Commission's review of the evidence leads us to a different conclusion.

The evidence shows Petitioner presented his permanent restrictions to Respondent and was advised no accommodated position was available. The evidence further shows, within a week of his June 14, 2016 release by Dr. Fernandez, Petitioner began a self-directed job search; he made at least 10 inquiries per week seeking positions where he would only have to use his left hand sparingly. Shortly thereafter, Respondent selected Vocamotive to provide formal vocational rehabilitation services. Petitioner's job search logs demonstrate he continued his self-directed job search pending the initiation of vocational rehabilitation.

The initial rehabilitation plan was submitted September 6, 2016. Therein, Ms. Stafseth determined the initial phase of Petitioner's vocational rehabilitation would be dedicated solely to computer training; after approximately 30 days, "job seeking skills instruction" would be added to the computer training curriculum; and actual job search activity was targeted to begin after approximately eight weeks. PX7. Over the next six months, Petitioner underwent vocational rehabilitation under Vocamotive's guidance. The Commission finds Vocamotive's records establish Petitioner was compliant with the program and cooperated fully throughout the process:

> October 30, 2016 Progress Report – Petitioner was "very polite and vested in the process"; no Vocational Counseling or Behavioral Self-Management issues identified
>
> November 29, 2016 Progress Report – "he is diligent in his work and has been cooperative in all aspects of training"; no Vocational Counseling or Behavioral Self-Management issues identified
>
> January 2, 2017 Progress Report – Petitioner has remained in computer training throughout this reporting period; no Vocational Counseling or Behavioral Self-Management issues identified
>
> February 5, 2017 Progress Report – it is noted that he should have completed computer training on January 10, 2017; however will still need to complete the current chapter of Word, complete the testing and email training before moving to fulltime job search. Mr. Sturm has increased his hours at this office at this time. Given his vocational testing results, it is unknown as to the reason he has continued to struggle with computer training. Vocational Counseling or Behavioral Self-Management – Mr. Sturm has fallen behind in computer training and has increased his hours at this office.

March 6, 2017 Progress Report – Mr. Sturm completed computer training and moved to fulltime job search at this time. He has been completing all of his itinerary items. He has been fully engaged in job search at this time. While he works slowly, he is very careful about the work he does and he does not make errors. No Vocational Counseling or Behavioral Self-Management issues identified. PX7.

As the above demonstrates, the only documented deviation from the vocational rehabilitation plan was it took Petitioner longer than anticipated to complete the computer training. Even so, at no point did Ms. Zajac or Ms. Stafseth equate this with non-compliance, a failure to cooperate, or a lack of good faith.

The Commission further observes that even though it was not required by Vocamotive, Petitioner on his own initiative continued his self-directed job search efforts. We find this compelling evidence of a good faith effort at vocational rehabilitation.

The Commission finds Petitioner was engaged in vocational rehabilitation as provided in Section 8(a) and as such is entitled to maintenance benefits. The Request for Hearing reflects the maintenance period was July 9, 2016 through March 20, 2017. Given Petitioner's stipulated average weekly wage of $1,639.33, Petitioner is entitled to maintenance benefits of $1,092.89 per week for 36 3/7 weeks. Respondent is entitled to a credit of $39,345.84 for maintenance benefits paid.

II. Wage Differential

Petitioner sought a wage differential award at arbitration. The Arbitrator concluded Petitioner failed to prove his entitlement to §8(d)1 benefits and instead awarded 40% loss of the person as a whole. The Commission views the evidence differently.

Under Section 8(d)1, an impaired worker is entitled to wage differential benefits when (1) he is "partially incapacitated from pursuing his usual and customary line of employment" and (2) there is a "difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." 820 ILCS 305/8(d)1. The evidence clearly demonstrates Petitioner's permanent restrictions prohibit him from returning to his pre-accident employment as a bricklayer. Therefore, the first element is satisfied.

As to the second element, in order to prove an impairment of earnings, "a claimant must prove his actual earnings for a substantial period before the accident and after he returns to work, or in the event that he has not returned to work, he must prove what he is able to earn in some suitable employment." *Crittenden v. Illinois Workers' Compensation Commission*, 2017 IL App (1st) 160002WC, ¶20, 73 N.E.3d 654, quoting *Gallianetti v. Industrial Comm'n*, 315 Ill. App. 3d 721, 730, 734 N.E.2d 482 (2000). As Petitioner has not returned to work, it was incumbent upon him to establish what he is able to earn in some suitable employment. Respondent argues Petitioner cannot meet this burden and places great importance on the fact Petitioner only had a month of

assisted job search prior to the hearing. Respondent's focus on the length of Petitioner's job search is misplaced. Rather, how a claimant would meet that burden was specifically addressed in *Crittenden*, which the Commission observes is of greater significance than the Arbitration Decision reflects. In *Crittenden*, the Court emphasized that while many cases had addressed the proper standard for determining the average amount an employee would be able to earn in the full performance of his duties in the pre-accident occupation, "no Illinois court has set forth an interpretation of the particular method the Commission is required to use to establish 'the average amount which [the employee] is able to earn in some suitable employment or business after the accident,' in the event that the employee has not returned to work. Accordingly, we find this to be an issue of first impression and proceed to interpret the Act to resolve this legal issue." *Crittenden*, ¶21 (Emphasis added). Analyzing the "straightforward and succinct" statutory language, the Court held, "In calculating this average amount...if the claimant is not working at the time of the calculation, the Commission must rely on functional and vocational expert evidence" to determine "the average amount which [the claimant] is able to earn in some suitable employment or business after the accident." *Crittenden*, ¶23. Suitable employment is employment in which the claimant is both able and qualified to perform. *Crittenden*, ¶24.

Here, the functional evidence is clear, as Dr. Fernandez's permanent restrictions are uncontradicted, and the sole vocational expert evidence is provided by Vocamotive. In her rehabilitation plan, Ms. Stafseth concluded Petitioner is employable and identified target jobs of front desk representative, customer service representative, and concierge; the projected wages for these positions was $10.00 to $12.00 per hour. PX7. Following vocational testing with Mr. Boyd, the target job list was expanded by adding customer order clerk, service dispatcher, procurement clerk, warehouse checker, billing clerk, surveillance system monitor, repair order clerk, service order expediter, and information clerk; significantly, the projected earnings remained the same: $10.00 to $12.00 per hour. When assisted job search ultimately began in February 2017, the job leads provided by Vocamotive were primarily for front desk, guest services, and customer service representative positions. Petitioner testified these are the job leads Vocamotive continues to provide: "the counter-type thing, like desk clerk for like a motel. Most of it was concierge work." T. 27. Therefore, the vocational evidence as provided by Respondent's chosen expert establishes Petitioner is "both able and qualified to perform" work as a concierge/customer service representative and the earnings range for those possible placements is between $10.00 and $12.00 an hour. Petitioner does not challenge Respondent's expert; to the contrary, Petitioner seeks to adopt the opinion of Respondent's expert as to what he is capable of earning in some suitable employment and thereby establish entitlement to a wage differential award.

The Commission finds Petitioner established both elements under §8(d)1. Our analysis necessarily then turns to the proper rate for that benefit.

Calculating the wage differential rate requires the Commission to make two earnings determinations: (1) "the average amount which he would be able to earn in the full performance of his duties in the occupation in which...he was engaged at the time of the accident," and (2) "the average amount which he...is able to earn in some suitable employment or business after the accident." 820 ILCS 305/8(d)1. With respect to what Petitioner's earnings would be if he was still employed as a bricklayer for Respondent, the February 17, 2017 missive from the International Union of Bricklayers and Allied Craftworkers evidences the union's base wage rate as of the

March 21, 2017 close of proofs was $44.88 per hour. PX8. Therefore, the average amount Petitioner would be able to earn in the full performance of his duties as a bricklayer with the City of Chicago is $1,795.20 per week ($44.88 x 40 = $1,795.20). As to the second earnings determination, the Commission relies on the vocational evidence detailed above and finds the suitable employment Petitioner is "able and qualified to perform" is 40 hours per week as a concierge/customer service representative earning $12.00 per hour. Therefore, the appropriate measure of Petitioner's earning capacity is $480.00 per week ($12.00 x 40 = $480.00). These figures yield a wage differential benefit of $876.80 per week ($1,795.20 - $480.00 = $1,315.20 x 66 2/3% = $876.80).

The Commission finds Petitioner is entitled to wage differential benefits of $876.80 per week commencing on March 21, 2017. As Petitioner's accident occurred after September 1, 2011, the §8(d)1 benefits will continue until Petitioner reaches the age of 67 or five years from the date the award becomes final, whichever is later.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,092.89 per week for a period of 44 4/7 weeks, that being the stipulated period of temporary total incapacity for work under §8(b) of the Act. Respondent is entitled to a credit of $48,713.90 for temporary total disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits under §8(a) in the sum of $1,092.89 per week for a period of 36 3/7 weeks. Respondent is entitled to a credit of $39,345.84 for maintenance benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $876.80 per week commencing March 21, 2017 and continuing until Petitioner reaches the age of 67 or five years from the date the award becomes final, whichever is later, as provided in §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.

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement.

The party commencing 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: JUL 2 - 2018

L. Elizabeth Coppoletti

LEC/mck

O: 5/9/18

Charles J. DeVriendt

43

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STURM, RONALD
Employee/Petitioner

Case# **14WC028015**

CITY OF CHICAGO
Employer/Respondent

18IWCC0418

On 4/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
RANDALL SLADEK
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0010 CITY OF CHICAGO DEPT OF LAW
ELIZABETH MANNION
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ronald Sturm
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # 14 WC 28015

18IWCC0418

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **3/21/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11/14/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$85,245.24**; the average weekly wage was **$1,639.33**.

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

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

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

Respondent shall be given a credit of **$48,713.90** for TTD, **$0** for TPD, **$39,345.84** for maintenance, and **$0** for other benefits, for a total credit of **$88,059.74**.

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

ORDER

With respect to Petitioner's claims of injuries to his left wrist, the Petitioner sustained a loss of occupation; thus, the Petitioner is entitled to have and receive from Respondent $721.66/week for 200 weeks, representing 40% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

The Respondent is entitled to a credit for maintenance benefits paid from period 7/19/16 through 3/17/17 (36 weeks).

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

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

David A. Kane
Signature of Arbitrator

April 5, 2017
Date

APR 5 - 2017

Ronald Sturm v. City of Chicago
14 WC 28015

FINDINGS OF FACT:

18IWCC0418

The parties stipulate that the City of Chicago (hereinafter referred to as the "Respondent") was operating under the Illinois Workers' Compensation Act on November 14, 2013. On said date Ronald Sturm (hereinafter referred to as the "Petitioner") sustained accidental injuries that arose out of and in the course of his employment with the Respondent. On this date he was working as a sewer bricklayer in the Department of Water Management. On this date, Petitioner was working when he was working, and a laborer above him lost control of a rope lowering a bucket of mortar, injuring Petitioner's left hand. Petitioner was 55 years old on the date of this incident. Petitioner is right-hand dominant.

Parties proceeded to hearing on December March 21, 2017, with disputed issues as to causation, nature and extent, and a maintenance credit.

Petitioner testified following his injury, he first sought treatment the next day following the November 14, 2013, incident at Mercy Works. X-rays were done of his left wrist at that time, showing no fracture. He also began treatment with Dr. Seth Levitz at Northshore Orthopedics. Dr. Levitz reviewed the MRI and X-rays taken and opined "the MRI shows a SL ligament injury but based on the fact that he already has arthritic changes consistent with SLAC wrist and there is not edema in the carpal bones, I do not think the SL tear is acute. With pre-existing arthritis, an injury can make the arthritis more painful and I think this is the case." (Px 5). He treated with physical therapy and an underwent a cortisone injection to his left wrist on January 23, 2014. Petitioner continued to work full duty until Dr. Levitz

placed work restrictions while treating on January 23, 2014. Petitioner continued to treat conservatively and received a full duty on March 13, 2014 per Dr. Levitz. (Px 5).

Petitioner continued to work full duty in the same position after his return to work, but he resumed treatment for his wrist on March 12, 2015. At this time, he began treatment with Dr. John Fernandez at Midwest Orthopaedics at Rush. Dr. Fernandez diagnosed Petitioner with left wrist scapholunate advanced collapse, active, and carpal tunnel syndrome, active. Dr. Fernandez discussed possible surgery at this time. Petitioner was kept at full duty, as long as his symptoms permitted him to do so. (Px 2, p. 20). Petitioner underwent an IME with Dr. Chris Huang on September 2, 2015. Dr. Huang agreed with Dr. Fernandez's recommendation of scaphoid excision and 4-corner fusion of the left wrist. (Px 4, p. 7-9). He was taken off work as of October 21, 2015.

Petitioner ultimately underwent a left wrist scaphoid excision with partial radial styloidectomy, midcarpal fusion, and carpal tunnel release with Dr. Fernandez on December 16, 2015. He underwent a second procedure for removal of hardware on March 2, 2016. (Px 1, p. 18, 66).

On June 14, 2016, Dr. Fernandez placed Petitioner at MMI, with permanent restrictions of light duty, "in the 10 pound range on average with regards to gripping, pushing, pulling use of tools, or use of machines with restrictions on significant repetition or loading and extension and flexion across the wrist." (Px 1, p. 8).

Petitioner testified he began his own self-directed job search on June 20, 2016. He applied for approximately 10 jobs per week. A substantial portion

of the jobs he applied for would knowingly exceed his restrictions, as he was applying for "stocker", "yard help", "stock person" positions. (Px 6). Additionally, Petitioner was enrolled in a formal vocational rehabilitation program, with his first initial meeting with the counselor taking place on October 4, 2016. (Px 7). The initial plan created prior to this meeting, on September 6, 2016, notes Dr. Fernandez's permanent restrictions of light duty, in the 10 pound range on average with regards to gripping, pushing, pulling, use of tools, or of machines with restrictions on significant repetition or loading and extension and flexion across the wrist. (Px 7).

In this initial report, the projected wages of $10-$12/per hour. (Px 7, , 9/6/16 Rehabilitation Plan). The rehabilitation goals note "to facilitate return to work to appropriate occupation within 150 days following training." The job targets were notes as front desk representative, customer service representative, concierge, and other occupations as appropriate. (Px 7, 9/6/16 Rehabilitation Plan). Vocamotive recommended vocational testing, computer skills training, and job seeking skills instruction, along with vocational counseling, behavioral self-management, and job search supervised and independent. (Id).

The October 30, 2016, Vocamotive Progress Report notes that Petitioner had been scheduled for vocational testing on October 12, 2016, and computer training. (Px 7). Petitioner underwent a vocational evaluation with JFBoyd. Ltd. On October 12, 2016, to assess his skill level and competitive employment opportunities, given his injury and resultant limitations to his left hand. (Px 7, p. 19). James F. Boyd, M.S., CRC, found that Mr. Sturm's language-based scores were higher than his education level would indicate, and his math computation skills corresponded to jobs requiring arithmetic computation as a non-essential job function. (Px 7, p. 21).

Overall, the results of the vocational assessment suggested aptitude an achievement levels to be compatible with the following job titles: management trainee, personnel scheduler, project manager, project estimator, customer order clerk, service dispatcher, procurement clerk, warehouse checker, billing clerk, surveillance system monitor, repair order clerk, service order expeditor, and information clerk. (Px 7, p. 27). When asked on cross-examination if he was made aware of the results of his testing and his job capabilities, he laughed in the middle of the hearing as a response.

The November 29, 2016 Vocamotive Progress Report shows Petitioner was still working on computer training and keyboarding, and began a Job Search Workshop, covering topics such as resumes, references, and template documents. (Px 7, p. 29). During this period, he was also introduced to Word tutorials. In this report, Vocamotive notes that Petitioner "inquired about his age being a factor with regards to employment." Vocamotive advised that this was a factor taken into consideration. Petitioner responded that "his age was considered to be a negative factor." (Px 7, p. 30). When questioned about this statement at arbitration hearing on cross-examination, Petitioner testified he did not recall it.

Petitioner did not complete a City of Chicago profile to look for different positions, and did not complete ADA paperwork to request reasonable accommodations within the City of Chicago. Vocamotive advised him to do so. At hearing, Petitioner testified that he refused to complete this paperwork because he is not "disabled", he is "injured."

Petitioner did not finish the job training portion of his formal vocational program and begin assisted job search efforts until February 16, 2017.

Petitioner was advised by Vocamotive that his job search through Vocamotive would be more vigorous, in that he would be expected to compete 40-60 employer contacts weekly, with Vocamotive support. (Px 7, p. 36). At the time of hearing, Petitioner had been in the job search portion of the program for approximately four weeks total. This case proceeded on Petitioner's Request for Hearing on March 23, 2017.

Petitioner testified that his educational background is that of a GED and approximately 3 ½ years of apprenticeship training for a bricklayer. He testified that he is a member of Local 21. A wage statement letter from his union was entered into evidence as Petitioner's Exhibit 8, stating a currently hourly rate of $44.88.

Petitioner testified and provided information in vocational testing that in his position as a sewer bricklayer for the City of Chicago, his job duties included building and repairing sewer structures, along with more administrative duties such as arranging for the necessary labor, engineers, excavation, and tools. (Px 7, p. 20).

Petitioner did not work as of the date of hearing and was still enrolled in Vocamotive, with his most recent meeting with the CRC the week prior.

CONCLUSIONS OF LAW:

To be compensable under the Workers' Compensation Act, the injury complained of must be one "arising out of and in the course of the employment." *Ill.Rev.Stat.1991, ch. 48, par. 138.2.* The claimant has the burden of establishing both requirements. (*Castaneda v. Industrial Comm'n* (1983), 97 Ill.2d 338, 341, 73 Ill.Dec. 535, 454 N.E.2d 632.) An injury "

'arises out of' one's employment if its origin is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury." *Jewel Cos. v. Industrial Comm'n (1974), 57 Ill.2d 38, 40, 310 N.E.2d 12.* "An injury is received in the course of employment where it occurs within a period of employment, at a place where the worker may reasonably be in the performance of his duties, and while he is fulfilling those duties or engaged in something incidental thereto." *Scheffler Greenhouses, Inc. v. Industrial Comm'n (1977), 66 Ill.2d 361, 367, 5 Ill.Dec. 854, 362 N.E.2d 325.*

When determining the above issues the Arbitrator must carefully weigh all of the evidence presented. This includes the credibility and testimony of the petitioner.

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

Overall, it appears Petitioner's current condition of ill-being is injury causally related to his work incident of November 14, 2013. Petitioner sustained an injury to his left wrist, which resulted in a partial fusion and CTS release, along with subsequent procedure to remove hardware. He was given permanent light duty restrictions as a result.

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

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of her claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524 (1987). This includes the nature and extent of a Petitioner's injury, including her entitlement to a wage differential award under section 8(d)1 of the Act. To obtain such a wage differential award, the Petitioner must provide sufficient

evidence of a definite loss of earning capacity once her condition has stabilized. *Gallianetti v. Indus. Comm'n*, 315 Ill. App. 3d 721, 728 (2000). Vocational rehabilitation is also often appropriate once the employee's condition has stabilized. Once the rehabilitation program has started the employee has a duty to fully cooperate in the program and its efforts to return him to work. *Archer Daniels Midland Co. v Indus. Comm'n*, 138 Ill.2d 107, 115-16, 561 N.E.2d 623, 626 (1990); *Hayden v. Indus. Comm'n*, 214 Ill. App. 3d 749, 756, 574 N.E.2d 99, 103-04 (1991) (denying benefits to claimant in the absence of good faith cooperation with vocational rehabilitation efforts).

The Illinois Court of Appeals recently rendered an opinion in the case *Crittenden v. IWCC* (2017 IL App. (1st) 160002WC). The sole issue on review in the *Crittenden* case was whether the circuit court erred by confirming the Commission's decision regarding the amount of the wage differential. Whether the employee was entitled to a wage differential was not reviewed or considered for determination. (See para. 18). The Appellate Court considered the issue of calculating the wage differential based on the employee's "suitable" employment, meaning evidence of what the employee is able and qualified to perform. (para. 24). The Court remanded this issue, finding that the $13.78 awarded by the Commission was not appropriate, as the employee did not possess a valid driver's license. (para. 26). The issue of the amount of the suitable wage has yet to be determined on remand and remains pending.

In the current case, Petitioner did not meet his entitlement to a wage differential. The record is clear that once a formal vocational effort began, Petitioner showed resistance with the effort, by telling the vocational counselor his age worked against him, despite her assurance it was only a

factor. Further, he no sooner completed job training through resume building, computer programs, and mock interviews, when this case proceeded for hearing on Petitioner's request for hearing. Petitioner only had 4 weeks of guided job search efforts prior to the hearing date. Additionally, Petitioner's responses on cross-examination show Petitioner's resistance to assistance in job searches. He refused to fill out paperwork for ADA accommodations, he laughed out loud in the hearing when he was asked whether he was advised that his skills testing showed him to be capable of jobs beyond his initial assessment, and he admitted he applied for numerous stocking positions, which requires lifting, and would be beyond his restrictions.

As a petitioner must not only show what he would be earning, but also what he is capable of earning in suitable employment, Petitioner's efforts in this case do not render a fair accounting of his capabilities for the latter element.

Thus, although Petitioner did suffer a loss of trade, in that he was unable to return to the same employment of sewer bricklayer, he did not meet his burden for a wage differential.

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) The reported level of impairment;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

Neither party submitted an AMA impairment rating for this case; however, this Arbitrator has considered each factor as listed under Sec. 8.1b of the Act.

Petitioner sustained injuries left hand which resulted in a partial fusion surgery and CTS release followed by removal of hardware. Petitioner was unable to return to his work as a bricklayer for the Respondent. Petitioner was 55 years old at the time of the incident, and his earning capacity was affected by his inability to return to his position with the Respondent. Petitioner has permanent light duty restrictions as a result of his left hand injury, which is corroborated by the medical records.

With respect to Petitioner's claims of injuries to his left wrist, the Petitioner is entitled to have and receive from Respondent $721.66/week for 200 weeks, representing 40% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Regarding (K) What temporary benefits are in dispute? Maintenance.

In the absence of "good faith" cooperation with vocational rehabilitation efforts, the termination of temporary total disability benefits is justified. Hayden v. Industrial Commission, 214 Ill.App.3d 749, 574 N.E.2d 99, 103, 158 Ill.Dec. 305 (1st Dist. 199). In the current case, although Petitioner was unable to return to his position as a sewer bricklayer, his lack of effort

in his independent job search and lack of pursuit of formal vocational efforts when offered support that Petitioner did not pursue a good faith job search to entitle him to maintenance benefits.

Petitioner testified he began his own self-directed job search on June 20, 2016. He applied for approximately 10 jobs per week. A substantial portion of the jobs he applied for would knowingly exceed his restrictions, as he was applying for "stocker", "yard help", "stock person" positions. This Arbitrator notes Petitioner was applying to positions that he would know to be outside his restrictions. Furthermore, Petitioner only participated in four weeks of formal job search efforts with Vocamotive, starting in February 2017, leading up to trial. Thus, as the record shows a lack of good faith effort and interest in obtaining suitable alternative employment, the Respondent is entitled to a credit back for maintenance benefits paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shirley Gustafson,
Petitioner,

vs.

Wal-Mart,
Respondent.

18IWCC0419

NO: 13 WC 39669

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 29, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $44,700.00. 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: JUL 2 - 2018
o6/28/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0419

GUSTAFSON, SHIRLEY
Employee/Petitioner

Case# **13WC039669**

WAL-MART
Employer/Respondent

On 12/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0560 WIEDNER & McAULIFFE LTD
BRIAN KOCH
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

18IWCC0419

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Shirley Gustafson
Employee/Petitioner

v.

Wal-mart
Employer/Respondent

Case # **13** WC **39669**

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 **Bloomington, Illinois**, on **11/28/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/12/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**4,690.03**; the average weekly wage was $**293.13**.

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

Respondent shall be given a credit of $**726.00** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $570.00 to Bloomington Radiology, $5,500.00 to Clinical Neurology Specialists, and $13,432.00 to Flamingo Surgery Center, $1,661.54 to Dr. Mark Perez, $61.00 to Steinberg Direct Medical Imaging, $3,445.00 to Select Physical Therapy, and $5,352.00 to Grabow Hand to Shoulder Center, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner the sum of $220.00/week for a further period of 69.575 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused **27-12% loss of use of the left arm**.

Respondent shall pay Petitioner compensation that has accrued from **6/18/14** through **11/28/17**, 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

12/27/17
Date

ICArbDecN&E p.2

DEC 29 2017

FINDINGS OF FACT:

Petitioner was employed as a part-time Maintenance Associate for Wal-Mart since June 6, 2013. Petitioner testified that on October 12, 2013, she tripped over a bench and noticed pain in her left elbow. Petitioner described her elbow as fine prior to October 12, 2013. She had not used any medications or seen any doctors or had any surgery for her left elbow.

Petitioner presented for initial medical treatment at the emergency room of St. Joseph Medical Center on October 12, 2013. Petitioner reported that she was trying to move a heavy bench at work earlier when she fell on concrete, landed on her left elbow and the left side of her forehead. She complained of pain in her left arm, a headache, and dizziness. X-rays taken of the left elbow showed an reduction of the distal humerus to the oclercranon tossa. There was an anterior fracture fragment which measured 1.8 cm and another fracture fragment projected posteriorly appeared to be within the joint space. X-rays taken of the left forearm additionally revealed a fracture and dislocation at the elbow joint. Petitioner was diagnosed with left elbow dislocation and chest contusion. She was given an arm sling, a posterior splint, prescribed Norco, and advised to consult an orthopedist. (PX 6)

On October 14, 2013, Petitioner presented to Dr. Oakey at McLean County Orthopedics with reported complaints of improving tingling that radiated into her fingers. Petitioner also reported pain medially and laterally with the elbow. Swelling was also noted. An examination revealed tenderness of the medial epicondyle and lateral epicondyle. There was tenderness on palpation and there was very limited motion secondary to pain. Dr. Oakey diagnosed a left fracture dislocation of the elbow and ordered a CT scan to better delineate the fracture pattern and opined that she would likely require surgical intervention. Petitioner was ordered off work for the next two weeks. (PX 7)

A CT scan of the left elbow was taken on October 16, 2013 and showed: (1) a minimally displaced fracture of the coronoid process of the ulna; (2) a comminuted fracture lateral epicondyle of the humerus; and (3) a 1.4 x 0.9 cm ossific fragment along the ventral aspect of the elbow joint that was likely a loose body from the fracture. (PX 5)

Petitioner returned to Dr. Oakey on October 21, 2013 when he recommended surgical intervention. (PX 7) On October 22, 2013, Dr. Oakey performed an open reduction and internal fixation of lateral condyle fracture and open reduction and internal fixation of left coronoid fracture. The post-operative diagnosis was left elbow lateral condylar fracture and coronoid fracture following dislocation. (PX4)

On November 1, 2013, Petitioner followed up with Dr. Oakey. She was given a hinged elbow brace and prescribed physical therapy. Petitioner was additionally released to return to work the following Monday with no use of the left arm. (PX 7)

Petitioner returned to Dr. Oakey on November 21, 2013. At that time, she reported that she was moving to Las Vegas the following day. Petitioner reported improvement, though she still had some residual burning pain. Additionally, she reported the tingling in her fingers was improving as well. Petitioner's restrictions were continued and she was provided with a physical therapy referral. (PX 7, PX 9)

On December 27, 2013 Petitioner presented with Dr. Ryan Grabow of Grabow Hand to Shoulder Center. The report noted Petitioner was not currently working and that she continued to have difficulty using the left arm with pain burning at the operative site medially. Physical examination noted hand stiffness with some

weakness of thumb extension and long finger extension that was opined to be consistent with radial nerve/PIN palsy which was resolving postoperatively. She could extend the wrist and fingers with some lag time. There was also limitation in making a fist. Dr. Grabow diagnosed 1.) elbow dislocation; 2.) lateral condylar fracture suture fixation, coronoid suture fixation, and radial head fragment excision; 3.) postop radial nerve/pin palsy resolving; and 4.) hand stiffness. Dr. Grabow recommended hand therapy and modified work duty with no use of the left hand. (PX 10)

Petitioner followed-up with Dr. Grabow on January 24, 2014. The doctor noted that her range of motion and strength in her left hand was improving but was still weak and shaking with lifting. Also noted was Petitioner's complaint of a painful bump on the ulna sub q border. Dr. Grabow added painful hardware (suture knot) to his diagnosis. The doctor noted Petitioner's palsy would improve with time but occasionally the weakness would be permanent. He further noted that the nerve pain was typical and should improve with medication and time. Dr. Grabow added that Petitioner should avoid trauma to the painful area on the forearm which should calm same down. If it didn't, he would remove it once she was fully healed. Petitioner was to continue her current physical therapy regime and was given a work restriction of no pushing, pulling, or lifting more than two pounds. (PX 10)

Dr. Grabow saw Petitioner again on February 21, 2014. Although Petitioner reported improvement in hand function and sensation, she noted pain at the elbow and arm with shoulder forward flexion and abduction. Dr. Grabow recommended physical therapy for the shoulder and elbow. Petitioner's work restrictions were unchanged. By March 4, 2014, Dr. Grabow noted Petitioner's weakness was improved at all extensors. She still had some lag of index and slight weakness of extensors. Petitioner's radial nerve/PIN palsy was also improving. Dr. Grabow stated that Petitioner's shoulder problem was due to the severity of her elbow trauma and surgery. As a result, she needed therapy to improve her shoulder motion and brachial plexus mobility. (PX 10)

On April 1, 2014, Petitioner returned to Dr. Grabow when she noted improvement with motion and pain but reported the suture area was still tender. Additionally, Petitioner noted her shoulder was still stiff and sore from her bracing. X-rays taken of the left elbow showed a healed fracture at the coronoid, a visible line at the lateral condyle but opined to be stable, and no obvious increase in HO. An examination revealed tenderness was present at the ulnar border where she had a painful suture. She had decreased range of motion of the shoulder which was limited by stiffness and pain. Petitioner was to continue physical therapy and was given the work restrictions of no overhead work and no lifting more than 10 pounds. Additionally, Dr. Grabow recommended that physical therapy be continued for another four weeks to focus on strengthening the left elbow and rotator cuff, scapular muscle, and gripping. (PX 10)

On April 22, 2014, a Utilization Review was performed that did not certify the additional requested physical therapy sessions. The reviewer, Dr. Martin Plotkin, reasoned that the physical therapy progress reports did not outline evidence of significant changed in Petitioner's objective and function status. Regarding the left shoulder, it was felt that there was no evidence of significant deficits directed to the left shoulder, as the majority of her symptoms were for the left elbow. (RX 7)

Petitioner returned to Dr. Grabow on April 30, 2014. The doctor noted she was still unable to make a fist and was very stiff in her shoulder. Dr. Grabow commented she has profound shoulder stiffness and pain and limited hand use due to an inability to make a fist. Dr. Grabow added left shoulder stiffness to his diagnoses. Dr. Grabow felt Petitioner was doing well at her elbow but her shoulder and had significant problems. He stated the denial of therapy is going to prolong her care and will result in severe permanent disability. The doctor continued his therapy recommendation and returned Petitioner to full duty work. (PX 10)

On May 28, 2014, Dr. Grabow noted there was no significant improvement in Petitioner's condition. She had been working on her own therapy. An examination of the elbow revealed tenderness at the ulnar hardware

site. She had pain with shoulder strength testing and she was still unable to make a fist. Dr. Grabow again recommend aggressive hand therapy. Dr. Grabow reinstituted work restrictions of no overhead work and no lifting more than 10 pounds. (PX 10)

On June 18, 2014, Dr. Grabow noted Petitioner had improved. Petitioner reported that she was improving with motion. She could make a fist but was limited in how firm. She was still reporting stiffness in the shoulder. Dr. Grabow commented that Petitioner continue to work on her hand stiffness and motion. He indicated she would improve with time. He noted that her elbow motion was normal and did not require further therapy. However, he noted that Petitioner's shoulder was still significantly stiff which necessitated formal therapy. The doctor felt that it was unlikely she would regain normal shoulder motion without the formal therapy. Dr. Grabow added that with the denial of therapy there was no other treatment that can be rendered. He felt she would likely have a higher degree of disability. Petitioner was discharged from care and returned to full duty work. (PX 10) Petitioner benefits were terminated at that time.

On December 23, 2014, Dr. Oakey authored a narrative report. He noted that the Petitioner tripped over a bench sustaining a fracture dislocation of the left elbow. He expressed his "substantial concern" that the lack of physical therapy would make her quite stiff at the elbow potentially requiring further treatment such as an elbow contracture release. He noted his November 21, 2013 chart note provided that Petitioner's fingers were stiff which could potentially be a long term issue without therapy. The doctor also opined regarding future medical consideration. He noted that in this intraarticular fracture, arthritis of the elbow is a very challenging problem to fix as well as painful hardware, which could necessitate hardware removal. Lastly, Dr. Oakey expressed his opinion that the surgery performed was causally connected to the injury Petitioner described. (PX 1)

At Respondent's request, Petitioner underwent an independent medical examination with Dr. James Manning in Nevada on February 24, 2015. After obtaining a history, performing an examination and reviewing Petitioner's medical records, Dr. Manning opined that Petitioner was 1.) postsurgical treatment of left elbow dislocation and lateral epicondylar fracture with satisfactory objective result; 2.) painful masses in the left elbow possible retained nonabsorbable sutures; 3.) atypical left hand stiffness uncertain etiology; and 4.) left shoulder pain uncertain etiology. Dr. Manning provided that "the objective result of the treatment of the elbow dislocation is satisfactory except the painful masses. Removing them would be a very minor procedure and would not compromise the result…" Dr. Manning had no opinion regarding Petitioner's hand stiffness indicating she should evaluated by a hand specialist. The doctor also indicated that if the shoulder is part of the claim, she would require a MRI scan with contrast. (RX 6)

Petitioner returned to Dr. Grabow on September 11, 2015. According to the records submitted, in the "Reason for Visit" Petitioner was categorized as "Established Patient with New Problem." Petitioner complaints consisted of left wrist pain that began two to three months without known cause. It was noted Petitioner complained of swelling and burning pain in the left wrist that radiated up to her left elbow. She had loss of grip strength. Petitioner complained of numbness and tingling localized in the left elbow and that most of her hand symptoms were from an old work comp claim that has closed. Also recorded was that her current symptoms seem to be associated with arthritis as well. Dr. Grabow recommended Petitioner undergo a hand arthritis therapy program. The doctor conveyed to Petitioner that her symptoms appear as a residual from her "old work comp." claim. He felt that much of the symptoms would not improve with any specific treatment. He added that nerve irritation would likely improve with time and medication. (PX 10)

Petitioner returned to Dr. Grabow on October 30, 2015 with left wrist pain after attending therapy two times a week and undergoing an EMG at Dr. Perez's office. Dr. Grabow noted that Petitioner's left hand function showed some residual radial/pin palsy from previous work comp injury as well as some ulnar sided irritation but negative flexion test and Tinel's at the elbow. Dr. Grabow's impression was 1.) status post left

elbow dislocation; 2.) status post lateral condylar fracture suture fixation, coronoid suture fixation, and radial head fragment excision; 3.) postop radial nerve/pin palsy resolving; and 4.) hand stiffness; 5.) painful hardware (suture knot); and 6.) shoulder stiffness. Medication was prescribed. (PX 16)

On December 22, 2015, Dr. Grabow noted Petitioner continued difficulties with sensation and grip. A left hand examination revealed numbness in the radial nerve distribution. Additionally, there was some numbness volarly which the doctor felt could be related to carpal tunnel. Dr. Grabow recommended bilateral EMG/NCV studies to determine if there was any compressive neuropathy. SLAC wrist was added to the diagnoses (PX 16)

On February 2, 2016, Dr. Grabow noted Petitioner was having pain at the left elbow at the knots from her previous surgery. Her numbness was still persistent. The doctor noted Petitioner's EMG results showed some carpal tunnel syndrome bilaterally and Guyon's on the left but not associated with symptoms. Dr. Grabow also noted Petitioner's painful hardware and recommended a left elbow painful hardware removal. (PX 16) On February 18, 2016 Dr. Grabow performed a left elbow painful hardware removal at Flamingo Surgery Center in Las Vegas, Nevada. (PX 14)

Postoperatively, Petitioner continued under Dr. Grabow's care on February 23, 2016, and June 15, 2016. On July 27, 2016, Petitioner underwent a left wrist joint steroid injection secondary to her complaints of left wrist pain. As of September 22, 2016, Dr. Grabow noted the left wrist injection was not helpful. Petitioner reported pain radiating up to her left elbow since the injection which she described as constant, dull and aching. Dr. Grabow also noted Petitioner reported left arm weakness. At that time, the doctor's impressions were 1.) shoulder pain; 2.) impingement syndrome – left shoulder; 3.) status post left elbow dislocation; 4.) status post lateral condylar fracture suture fixation, coronoid suture fixation, and radial head fragment excision; 5.) postop radial nerve/pin palsy resolving; 6.) hand stiffness; 7.) painful hardware (suture knot); 8.) SLAC wrist; and 9.) shoulder stiffness. Dr. Grabow recommended a left shoulder subacromial injection. (PX 14)

Petitioner testified and records submitted show that on October 7, 2013, she notified Respondent of her intention to resign from her employment effective October 22, 2013. (RX 1) Petitioner stated she did so because "they wouldn't let me go back to work." She also stated that she had planned on retiring and moving to Las Vegas. She intended for the resignation letter to show effective November 2013. Records submitted show Petitioner accepted a temporary alternative duty job position on November 4, 2013. According to the document, Petitioner was to report to work on November 5, 2013. (RX 2) Petitioner was terminated on December 3, 2013. (RX 3)

Petitioner testified that she has difficulty moving her fingers. She experiences a burning and stinging sensation. She has difficulty lifting her left arm over her head. She also has difficulty getting dressed and at times, she has difficulty with household chores.

All of Petitioner's medical treatment was processed by Respondent through June 18, 2014. Petitioner testified that she processed all of her treatment in 2015 and thereafter through Public Aid. Petitioner testified that she has a child support lien from the State of Michigan. The Arbitrator notes that the parties are subject to the child support order issued to Respondent on January 7, 2017. (RX 9)

WITH REGARD (F) CAUSAL CONNECTION, THE ARBITRATOR FINDS THE FOLLOWING:

The Arbitrator finds that a causal relationship exists between Petitioner's two surgical procedures and her injury sustained on October12, 2013. It is undisputed that Petitioner sustained an accident on October 12, 2013 when she tripped over a bench and noticed pain in her left elbow. It's also undisputed that the surgery performed on October 22, 2013 is related to the undisputed accident. Respondent disputes that any treatment to

the left arm after Dr. Grabow's June 18, 2014 release from care is not causally related to the accident. Respondent asserts that because Petitioner sought no treatment between June 18, 2014 and September 22, 2015, said gap is significant and sufficient to break the causal relationship between Petitioner claim, of accident and her need for further treatment beyond June 18, 2014. The Arbitrator disagrees.

Prior to Dr. Grabows release from care, the doctor consistently opined that Petitioner would benefit from additional formal therapy. On April 30, 2014, Dr. Grabow commented she had profound shoulder stiffness and pain and limited hand use due to an inability to make a fist. He felt the denial of therapy was going to prolong her care and would result in severe permanent disability. By June 18, 2014, Dr. Grabow noted that with the denial of therapy there was no other treatment that could be rendered and discharged her from care. Dr. Grabow's concern was borne out by Petitioner return for treatment in September 2015. At that visit, the doctor conveyed to Petitioner that her symptoms appear as a residual from her "old work comp." claim. He felt that much of the symptoms would not improve with any specific treatment. Petitioner still had nerve irritation complaints which the doctor continued to feel would likely improve with time and medication. Petitioner returned to Dr. Grabow on October 30, 2015. Dr. Grabow noted that Petitioner's left hand function showed some residual radial/pin palsy from previous work comp injury as well as some ulnar sided irritation. Also noted was a diagnosis of painful hardware (suture knot) which had been present since January 2014. On February 2, 2016, Dr. Grabow noted Petitioner was having pain at the left elbow at the knots from her previous surgery. Dr. Grabow recommended a left elbow painful hardware removal which was performed on February 18, 2016.

The Arbitrator notes that Dr. Oakey forecasted that she may have additional surgery to the elbow. On December 23, 2014, expressed his "substantial concern" that the lack of physical therapy would make her quite stiff at the elbow potentially requiring further treatment such as an elbow contracture release. He noted his November 21, 2013 chart note provided that Petitioner's fingers were stiff which could potentially be a long term issue without therapy. The doctor also opined that with this intraarticular fracture, arthritis of the elbow is a very challenging problem to fix as well as painful hardware, which could necessitate hardware removal.

The Arbitrator also notes the independent medical examiner, Dr. James Manning, opinion on February 24, 2015. Dr. Manning opined that Petitioner was 1.) postsurgical treatment of left elbow dislocation and lateral epicondylar fracture with satisfactory objective result; 2.) painful masses in the left elbow possible retained nonabsorbable sutures; 3.) atypical left hand stiffness uncertain etiology; and 4.) left shoulder pain uncertain etiology. Dr. Manning provided that "the objective result of the treatment of the elbow dislocation is satisfactory except the painful masses. Removing them would be a very minor procedure and would not compromise the result..." Dr. Manning had no opinion regarding Petitioner's hand stiffness nor the shoulder complaints.

Relying on all the above, the Arbitrator finds that a causal relationship exists between Petitioner's present left arm condition of ill-being and the accident sustained on October 12, 2013.

WITH REGARD TO (J) REASONABLENESS AND NECESSITY OF MEDICAL TREATMENT, THE ARBITRATOR FINDS THE FOLLOWING:

Having found the requisite causal relationship, the Arbitrator awards the medical bills contained in Petitioner's Exhibit Number 17.

WITH REGARD TO (L) NATURE AND EXTENT, THE ARBITRATOR FINDS THE FOLLOWING:

As this accident occurred on June 11, 2014 (AX 1), this claim is subject to Section 8.1b of the Illinois Workers' Compensation Act, which provides that for accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

In accordance with Section 8.1b of the Act, the Arbitrator has considered the following factors when reaching his decision regarding the issue of permanency:

(i) The reported level of impairment pursuant to subsection (a): The parties did not submit a rating for this claim and offered no evidence to address this factor. Therefore, the Arbitrator gives this factor no weight.

(ii) The occupation of the injured employee: Petitioner was employed as an associate by Respondent. She is able to return to work in her prior capacity. Therefore, the Arbitrator gives no weight to this factor.

(iii) The age of the employee at the time of the injury: Petitioner was 57 years old at the time of her accident. As she was approaching the sixth decade of life, she will live with her disability for a shorter period that a younger individual. As such, the Arbitrator gives little weight to this factor.

(iv) The employee's future earning capacity: The evidence shows that Petitioner was returned to work on full-time basis unrestricted basis by Dr. Grabow as of June 18, 2014. Therefore, the Arbitrator gives no weight to this factor.

(v) Evidence of disability corroborated by treating records: Petitioner underwent an open reduction and internal fixation of lateral condyle fracture and open reduction and internal fixation of left coronoid fracture. The post-operative diagnosis was left elbow lateral condylar fracture and coronoid fracture following dislocation. Thereafter, Petitioner underwent a course of protracted treatment culminating in a left elbow painful hardware removal on February 18, 2016. At trial, Petitioner credibly testified to continuing complaints.

Taking into account the aforementioned factors, the Arbitrator finds that Petitioner sustained injuries resulting in permanent disability of 27-1/2% loss of use of use of the left arm, pursuant to Section 8(e) of the Act. The parties shall be bound by the State of Michigan Office of Child Support Notice to Carrier regarding issuance of award to Petitioner.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Stercay,
Petitioner,

vs.

City of Oak Forest,
Respondent.

18IWCC0420

NO: 16 WC 16468

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 20, 2017, is hereby affirmed and adopted.

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

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

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

DATED: JUL 2 - 2018
o6/28/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
8(A)

18IWCC0420

STERCAY, MICHAEL
Employee/Petitioner

Case# **16WC016468**

CITY OF OAK FOREST
Employer/Respondent

On 9/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2194 STROM & ASSOCIATES
JOSEPH MULVEY
180 N LASALLE ST SUITE 2510
CHICAGO, IL 60601

2337 INMAN & FITZGIBBONS LTD
STEPHEN McCLARY
33 N DEARORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
8(A)

Michael Stercay
Employee/Petitioner

v.

City of Oak Forest
Employer/Respondent

Case # 16 WC 16468

Consolidated cases: N/A

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

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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. [ ] Were the 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 **Entitlement to prospective medical benefits**

FINDINGS

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

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

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

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

Petitioner's condition of ill being is not related to an accidental injury.

In the year preceding the injury, Petitioner earned **$70,304.00**; the average weekly wage was **$1,352.00**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

THE ARBITRATOR FINDS THE PETITIONER FAILED TO PROVE HE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT ON NOVEMBER 13, 2015. THE ARBITRATOR FINDS THE PETITIONER FAILED TO PROVE A CAUSAL RELATIONSHIP BETWEEN HIS LEFT KNEE CONDITION AND THE ALLEGED INCIDENT OF NOVEMBER 13, 2015. THE ARBITRATOR DENIES ALL BENEFITS INCLUDING THE PETITIONER'S REQUEST FOR PROSPECTIVE MEDICAL BENEFITS.

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

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

Signature of Arbitrator

September 19, 2017
Date

SEP 20 2017

Michael Stercay v. City of Oak Forest

16 WC 16468

ARBITRATOR'S DECISION:

I. Statement of Facts:

a. Testimony of Petitioner:

The Petitioner testified that he was employed as a maintenance worker for the City of Oak Forest and had been so for 13 years (TR. 9). The petitioner testified as to the nature of the work duties he performed for the respondent prior to his employment with the Respondent (TR. 10).

The Petitioner recalled that on November 13, 2015 he went to get into a street sweeper that he would be operating that day when he felt pain in his left knee due to the manner that he entered the vehicle in an awkward position (TR. 11). He stated that this occurred at the beginning of his day. He thought that his injury was not serious and that he had just strained something (TR. 13).

The Petitioner stated that he had discussed his injury or accident with his supervisor within a few days after November 13, 2015 (TR. 15-16). He testified that he told his supervisor that he had hurt his leg when he was getting in his machine that that was why he was limping (TR. 16). Petitioner testified that he did not seek medical care immediately nor did he fill out an accident report at the time of this alleged discussion (TR. 16-17). Petitioner testified that he did not remember the exact date when he first sought medical care but said it was at least a month after the accident (TR. 17-18).

After he did seek medical care he was prescribed physical therapy. When that was unsuccessful he was seen by an orthopedic surgeon who recommended surgery. He had not undergone surgery as of the date of Arbitration but wished to do so (TR. 18-19).

The Petitioner stated that he had previously injured his right shoulder while working and did not immediately fill out a written incident report but continued to work while his shoulder condition deteriorated (TR. 19-20). He stated that his supervisor was Joseph Petrizzo at the time of shoulder injury.

The Petitioner was asked to examine and identify a December 10, 2015 accident report that he had filled out (TR. 21-22).

The Petitioner testified that he was seen by Dr. Pietro Tonino for an independent medical examination. Dr. Tonino recorded a history from petitioner which indicates the he claimed to have reported the incident to his boss, Joe, on the day of the injury. (TR. 23-24). The Petitioner stated that was possible because "he was the one that kept asking me why I was limping, and I kept telling him when I got in the sweeper that's when I hurt my knee." (TR. 24-25).

The Petitioner testified that no formal report of the injury was made until December 10, 2015 (TR. 26).

The Petitioner stated that he would have had his initial conversation with his supervisor in the garage but he could not remember where that conversation took place or what was said (TR. 30). When asked whether his supervisor said anything about preparing a formal report he said that he did not instruct him to fill out a report (TR. 30-31). The petitioner testified that he did not receive medical care until after the first of the year (TR. 31-32).

b. Testimony of Joseph Petrizzo

Mr. Petrizzo testified that he was employed by the Respondent as Street Superintendent and had held that position for 11 years (TR. 36). In this position, he handled the daily operations which involved assigning jobs (TR. 36). He was Petitioner's supervisor and had worked with him for 10 years.

Mr. Petrizzo testified that as of November 13, 2015 the Petitioner would report work injuries to him (TR. 37). He did not notice the Petitioner limping or favoring a leg on that day. Had he noticed the Petitioner limping he would have inquired as to the reason.

Mr. Petrizzo testified that on December 10, 2015, the petitioner came to him and stated that he was injured and was directed to fill out an accident report (TR. 38). Petrizzo also testified that he had daily contact with the petitioner between November 13, 2015 and December 10, 2015 (TR. 38-39). Petrizzo testified that if he would have had a conversation with petitioner before December 10, 2015 about being injured he would have reassigned him so that his work did not impact his injury (TR. 39).

Mr. Petrizzo testified that after the Petitioner filled out the accident report he discussed with him about reporting accidents right away (TR. 40).

Mr. Petrizzo further testified that he remembered the petitioner having a shoulder injury in 2010 and missing work due to surgery (TR. 41). Petizzo testified that he remembered the Petitioner filling out an accident report right away after that accident. Mr. Petrizzo stated that he

had no conversations with the Petitioner about injuring his knee before December 10, 2015 (TR. 47).

c. Testimony of Dr. Pietro Tonino

Respondent took the evidence deposition of Dr. Tonino on November 2016 (Rx. 2). Tonino testified that he performed an independent medical examination (IME) on April 18, 2016. He took a history from the petitioner of injuring his left knee on November 13, 2015 when he was climbing into a truck over some materials and twisted the knee. Tonino testified that petitioner stated that he reported this to his supervisor the same day who observed him limping around. No formal accident report was made until December 10, 2015 (Rx. 2, p. 7). Dr. Tonino clarified that this was the history provided to him by the petitioner (Rx. 2, p. 8).

Dr. Tonino diagnosed a possible left sided medial meniscus tear and arthritis (Rx. 2, p. 11). He suggested left knee arthroscopy. Dr. Tonino testified that he found that the petitioner's condition was not related to a work injury because it was not reported to his supervisor until December 10, 2015 (Rx. 2, p. 15). Dr. Tonino reiterated on cross-examination that if the petitioner did not report the incident to his employer until December 10, 2015 that he would not find his condition related to a work injury (Rx. 2, pp. 18-22). Dr. Tonino went on to state that meniscal injuries can occur from just normal day to day activities (Rx. 1, p. 22).

d. Relevant Medical Records

The Petitioner was initially seen for treatment on January 27, 2016 at Ingalls Occupatonal Medicine Clinic (Px. 1). He stated that on November 13, 2015 he was trying to get into a street sweeper when the door would not open completely because it was parked too closely to another vehicle. He strained his left knee moving sideways trying to get into the vehicle. The Petitioner was prescribed physical therapy and permitted to work full duty. The physician's assistant who saw him stated that the cause of his condition was related to work activities.

On April 14, 2016, the Petitioner was seen by Dr. Henry Fuentes of Parkview Orthopaedics (Px. 2). Dr. Fuentes received essentially the same history and diagnosed a medial meniscus tear. He noted that physical therapy had not improved his condition. Dr. Fuentes administered a cortisone injection into the knee.

On May 5, 2016, Dr. Fuentes noted that the petitioner had relief from the injection but the pain returned. He further noted that Dr. Tonino had recommended surgery and Dr. Fuentes recommended surgery.

The February 22, 2016 MRI report contained within the records of Parkview showed tricompartmental degenerative changes in the knee as well as a complex degenerative tear of the posterior horn of the medial meniscus.

II. Conclusions of Law:

With respect to (C), did petitioner sustain an accident arising out of and in the course of employment, the Arbitrator finds as follows:

This entire case revolves around whether the Arbitrator finds the petitioner to be credible in his claim that he sustained an unwitnessed accident and injured himself on Friday, November 13, 2015. Petitioner's credibility is weighed against that of his supervisor.

The Petitioner testified at the Arbitration Hearing that he reported this accident within a week of its' occurrence. He was unable to state what date he specifically reported the accident. Conversely, on cross-examination he then stated that he might have reported the accident on the date of its' occurrence as Dr. Tonino had indicated in his report. In fact, Dr. Tonino reported that Petitioner had specifically stated to him that he reported the accident on the date of its' occurrence after his supervisor noticed him limping. He offered no explanation as to why the accident report was prepared on December 10, 2015. He did not deny that the accident report was prepared that date. The Arbitrator finds that petitioner's memory of reporting this accident is inconsistent. The Arbitrator can find no credible reason as to why the Petitioner would not remember whether he reported this incident on the date it allegedly occurred. Again, he provided no logical reason as to why or how the accident received a formal report on December 10, 2015. When asked when he first received medical care, Petitioner initially stated it was after a month but subsequently stated it was after the first of the year.

The Petitioner seems to suggest that late formal reporting was a pattern from a 2010 shoulder injury but offers no evidence of this other than his testimony that the prior injury was not formally reported on the date of its' occurrence. Mr. Petrizzo testified that the prior shoulder injury was recorded on the date it was reported. The Arbitrator has no evidence to the contrary.

Petitioner's supervisor testified that he was not aware of any claim of an accidental injury until December 10, 2015, approximately 3 ½ weeks after this alleged incident. There is nothing in the record which controverts this testimony of Mr. Petrizzo. He stated that he did not observe Petitioner limping or favoring his leg and would have inquired of Petitioner if he had. He consistently stated that on December 10, 2015 Petitioner came to him reporting the injury and it was documented that date.

The Arbitrator also notes that Petitioner received no treatment concurrent to the alleged accident date and, in fact, received no medical care allegedly related to the accident until approximately 2 ½ months after its occurrence. The Arbitrator observed the witnesses, listened to their testimony and observed their demeanor. The Arbitrator specifically finds the testimony of Joseph Petrizzo to be consistent and credible. The Arbitrator finds the testimony of the petitioner to be less credible than that of Mr. Petrizzo. The Arbitrator notes certain inconsistencies in the testimony of petitioner and multiple instances in which he was appears uncertain about when he reported the accident or when he first received medical care.

Based on the above, the Arbitrator finds that the Petitioner has failed to prove he sustained an accident arising out of and in the course of his employment on November 13, 2015.

With respect to (F) whether the petitioner's current condition of ill-being is causally related to the injury:

The Arbitrator notes that all the objective findings on the MRI are primarily degenerative in nature. The Arbitrator also notes the medical opinion of Dr. Tonino that he did not believe a causal relationship existed between the petitioner's left knee condition and the alleged incident of November 13, 2015 based on the presumption that petitioner did not advise his supervisor of the alleged November 13, 2015 incident until December 10, 2015. The Arbitrator notes his previous finding that he believed the testimony of Joseph Petrizzo to be credible on the date the alleged incident was reported and therefore adopts the opinions of Dr. Tonino on the issue of causal relation.

Based on the above, the Arbitrator finds that the petitioner failed to prove a causal relationship between his left knee condition and the alleged incident of Novemeber 13, 2015

With respect to (O) Other (prospective medical care):

The petitioner's request for prospective medical care is denied based on the petitioner's failure to prove that he sustained accidental injuries arising out of and in the course of his employment on November 13, 2015 and the petitioner's failure to prove a causal relationship between his left nee condition and the alleged incident of November 13, 2015.

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)
WILLIAMSON		☐ PTD/Fatal denied
	☒ Modify: Up	☒ None of the Above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEVEN N WILLI,

Petitioner,

18IWCC0421

vs. NO: 13 WC 30756

STATE OF ILLINOIS – CENTRAL MANAGEMENT SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms and adopts the Decision of the Arbitrator regarding the determination that Petitioner proved a causal connection between his work-accident and the condition of ill-being of his left hand but did not prove a causal connection between an alleged work accident and the condition of ill-being of his left shoulder. The Commission also affirms and adopts the Decision of the Arbitrator regarding the issue of medical expenses.

Regarding the extent of Petitioner's permanent partial disability, Petitioner is a foreman carpenter. He sustained a stipulated accident on July 20, 2012 in which he sustained a laceration and crush injury to his left hand while cutting wood with a miter saw. He suffered a severe laceration (requiring 11 stiches), commutated fracture of his left thumb, traumatic carpal tunnel syndrome, and traumatic Kienbock syndrome. He underwent two surgeries, a wrist radial shortening osteotomy with implantation of hardware and a carpal tunnel release with removal of the implanted hardware. Petitioner was released to work at full duty as on October 21, 2013.

18IWCC0421

Petitioner testified that currently he had constant ache throughout the back of his hand, which increases in rainy weather. He lost 42% of his thumb pad, he had no real feeling in his left thumb, and it felt "extremely strange" to grip anything. At work he still uses sledge hammers, saws, and vibratory tools. However, use of such tools is extremely painful, he avoids their use as much as possible, and he puts "that to subordinate employees." He still uses Tramadol and Ibuprofen, alternating their use. Both Dr. Sudekum, Petitioner's hand surgeon, and Dr. Mall, Petitioner's shoulder surgeon (condition not compensable), opined that Petitioner would require significant future surgery on his left wrist, either a carpectomy or fusion.

The Arbitrator weighed the statutory factors in determining permanent partial disability and awarded Petitioner 57.4 weeks of benefits representing loss of the use of 28% of his left hand. The Commission has no specific objection to the analysis of the Arbitrator. However, the Commission places a little more weight on the difficulty he has in working his current job duties and the likelihood of future surgery which could affect his overall impairment and future earning capacity. Based on the entire record before us, the Commission finds that an award of 71.75 weeks of permanent partial disability benefits representing loss of the use of 35% of the left hand. Accordingly, the Commission modifies the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 71.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 35% of the left 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: JUL 2 - 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-6/7/18
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0421

WILLI, STEVEN N
Employee/Petitioner

Case# **13WC030756**

SOI/IL DEPT OF CENTRAL MANAGEMENT SERVICES
Employer/Respondent

On 1/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH 7 COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

JAN 24 2017

ARNOLD A. RASSIA, 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

STEVEN WILLI
Employee/Petitioner

Case # **13** WC **30756**

v.

Consolidated cases: _____

STATE OF ILLINOIS/IL DEPT OF CENTRAL MANAGEMENT SERVICES
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 **Herrin**, on **July 7, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 20, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is*** causally related to the accident, **with regard to his left thumb, hand, and arm only. His left shoulder condition is not causally related.**

In the year preceding the injury, Petitioner earned **$68,042.00**; the average weekly wage was **$1,308.51**.

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

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

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

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

Respondent is entitled to a credit of $**any medical benefits paid through its group carrier** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Petitioner did not sustain an injury to his left shoulder in the accident of July 20, 2012. All benefits related to the left shoulder are denied.

Respondent shall pay Petitioner the sum of **$712.55/week** for a period of **57.4 weeks** as provided in **Section 8(e)** of the Act, because the injuries sustained caused a **28% loss of use of the left hand.**

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

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

Signature of Arbitrator

January 19, 2017
Date

JAN 24 2017

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

STEVEN WILLI
Employee/Petitioner

v. Case #: **13 WC 30756**

STATE OF ILLINOIS/IL DEPT OF CENTRAL MANAGEMENT SERVICES
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that Petitioner sustained an accident on July 20, 2012, which arose out of and in the course of his employment, causing injury to his left thumb, wrist, and forearm. The parties disputed whether Petitioner sustained injury to his left shoulder in the accident, and Respondent denied all liability with regard to the shoulder, including causal relationship and medical costs. Also at issue was nature and extent of the injuries.

At the time of the accident, Petitioner was 49 years old, single, with no dependent children, and was employed by Respondent as a Carpenter Foreman. He testified that on July 20, 2012, he was cutting blocks of wood with a 16-inch saw when the "block hit, ram it up and just threw me up over my shoulder, mashed my thumb". He further testified, "My thumb was hanging, say, two and three quarter, three inches longer than it is right now." He had immediate pain in his left thumb, hand, wrist, and forearm. He went to the emergency room, where the wound was surgically repaired. After some time he was referred by Tri-Star Risk Management to Dr. Sudekum, who performed a second surgery to remove part of the radial bone and put in a plate. He testified this did not help his condition and he eventually underwent a third surgery by Dr. Mall, which greatly improved his condition.

Petitioner testified that he continues to have constant soreness in his arm, thumb, and the back of his hand, primarily where the bone was removed. He lost 42% of his thumb pad and has no feeling in that area, has decreased ability to grip, and has decreased strength. He currently takes Tramadol and Ibuprofen on a daily basis for his symptoms. He testified he was a lifelong golfer but can no longer play due to the pain. He was also a lifelong duck hunter and can no longer go unless someone else takes him, due to the vibration of operating the motor shaft on his boat. He returned to the job he had at the time of the accident and continues to swing sledge hammers and use saws and vibratory tools. He tries to avoid these heavy activities, especially the vibratory activities, as they cause extreme pain.

With regard to his left shoulder, Petitioner testified that he had no symptoms, complaints, treatment, or tests prior to his accident. He further testified that he reported his shoulder pain to the emergency room and to every doctor he saw thereafter.

On cross-examination, Petitioner testified he is right-hand dominant and confirmed he was working full duty with no restrictions.

Respondent submitted several injury reports, including an Employee's Notice of Injury dated June 30, 2012, a Supervisor's Report of Injury completed by Jeff Mason on July 20, 2012, and a Witness Report completed by Gary Woodside on July 20, 2012. All the reports are consistent with regard to the facts of the accident. RX2, RX3, RX5.

Following the accident, Petitioner presented to Marshall Browning Hospital emergency department on July 20, 2012. He reported he had cut his left thumb with a miter saw while at work. It was noted there was an irregular laceration with tissue loss across the thumb pad. Five sutures were placed and a dressing was placed on the wound. Petitioner was instructed to follow up in two weeks for suture removal. PX3.

On July 23, 2012, Petitioner presented to Christopher Rural Health (aka REA Clinic) and was seen by Physician's Assistant Michael Poiter. It was noted he had "partial amputation of left thumb", which was reattached with seven stitches (two through thumbnail). The skin was intact with no sign of inflammation and the wound was rewrapped. Petitioner returned on July 27, 2012, and reported his symptoms had worsened and were aggravated by pressure and movement. On examination, the thumb was very tender to palpation, with decreased mobility, joint pain, and localized swelling. He was started on antibiotics, taken off work, and referred to an orthopedist. PX4. X-rays revealed a comminuted fracture of the distal tuft of the left thumb. PX5.

On August 2, 2012, Petitioner presented to Dr. Steven Young at Orthopaedic Institute of Southern Illinois. He gave a consistent history of the accident and his treatment to date. On examination, there was noted to be a darkened area at the tip of his left thumb, which was tender to palpation. Sutures were removed and he was allowed to return to modified duty, with no use of the right upper extremity. PX6. Petitioner returned to PA Poiter on August 3, 2012, and it was noted the laceration was improving but there did appear to be some discharge from the wound. PX4. He returned to Dr. Young on August 20, 2012, and repeat x-ray showed the fracture was healing. He was allowed to continue working modified duty, with no lifting over ten pounds with his left upper extremity. The Arbitrator notes there was not an actual narrative office note included in the records for this appointment. PX6.

Petitioner was next seen by Dr. Young and his Physician's Assistant Phil Erthall on September 25, 2012. He reported continued hypersensitivity in the thumb, as well as pain in the wrist. On examination, there was a deformity of the nail and the new nail was growing underneath. He had tenderness to palpation of the scapholunate area and in the ulnar aspect of the wrist. He also had slight decreased range of motion of the wrist. Left thumb x-rays showed the fracture site was healed. Left wrist x-rays revealed sclerotic changes of the lunate, consistent with Kienbock's. Dr. Young discussed Kienbock's disease with Petitioner, including its

progression and possible surgical treatment, and noted that he had probably had a traumatic flare up of the wrist. Petitioner reported he had never had any wrist pain until after his thumb injury at work. Dr. Young noted he could benefit from surgery, with various options on the type of procedure, including radial shortening, drilling of the lunate, or lunate bone graft. It was noted Petitioner was a smoker, which could have a negative impact on a radial shortening, and that he currently did not want surgery. Dr. Young noted he would have a difficult time saying this was related to a table saw injury to the thumb, but believed it was more likely due to substantial force or fall or torque to the wrist. Petitioner underwent an injection into the wrist and was instructed to wear a wrist cockup splint and to lift no more than ten pounds. PX6.

Petitioner returned to Dr. Young on October 22, 2012. Examination of the thumb revealed good range of motion, but pain with sharp pressure against the tip. Examination of the wrist was painful. He was released to return to work without restrictions. He followed up with Dr. Young on January 14, 2013, and reported continued pain in the thumb and wrist. He was overall satisfied with the progression of the thumb, but continued to have a problem with pinching or pushing buttons, and continued to have pain with any movement that caused pressure on the tip of the thumb. He continued to report pain in his left wrist, especially when the wrist was stressed. X-rays were again consistent with Kienbock's, with one millimeter ulnar negative variance, but it was noted it did "not appear that the lunate is in several pieces as of yet". Dr. Young recommended a more conservative wrist arthroscopy with possible arthrotomy and bone graft, rather than a radial shortening, and he allowed Petitioner to work in the meantime. PX6.

On January 29, 2013, Petitioner presented to Dr. William Hays, primarily in follow up for high blood pressure, allergic rhinitis, and stress. He also reported he had been diagnosed with Kienbock's disease and wanted to get a second surgical opinion prior to going forward with surgery. Dr. Hays provided a referral to Dr. Richard Gelberman. PX7.

Petitioner presented to Dr. Gelberman at Washington University Department of Orthopedics on February 11, 2013. He reported, "He caught a piece of wood with his radial miter saw which struck his thumb and wrist and forced it back against the safety guard of the saw with a severe twisting/compression injury to his left wrist in July of 2012." Wrist x-rays revealed two millimeters of negative ulnar variance, a radioscaphoid angle of 40 degrees, and sclerotic changes on the lunate, indicative of Stage III Kienbock's disease. Dr. Gelberman recommended radial shortening. PX8, PX9.

On February 25, 2013, Petitioner was evaluated by Respondent's Section 12 physician, Dr. Anthony Sudekum at Missouri Hand Center. He reported he was using a block of wood to push or hold another piece of wood into the miter box and the saw kicked back. His left thumb was crushed between the wooden box and the saw guard, and his left wrist was apparently forced into hyperextension. Petitioner advised he had complained of wrist pain in the emergency room, but "he felt that the ER staff was more focused on his thumb laceration and didn't pay attention to his left wrist complaints". He reported he had no prior problems with his left thumb or wrist, and that since the accident he had experienced gradually increasing pain, stiffness, and swelling of the left wrist. RX6, PX10.

On examination, Petitioner's left thumb and thumbnail had healed completely. With regard to the wrist, there was mild swelling and tenderness, with increased pain at the end ranges of motion. Fluoroscopic x-rays of both hands and wrists were obtained, which revealed three millimeters of ulnar negative variance on the left, compared to no variance on the right. Dr. Sudekum's assessment was Stage III Kienbock's disease (avascular necrosis of the lunate bone) of the left wrist. Dr. Sudekum opined there were several etiologic factors in Petitioner's development of the disease, including his own anatomy and his long history of extremely heavy smoking. In addition, however, Dr. Sudekum noted that Kienbock's can also be affected by prolonged manual activity and/or direct traumatic injury to the wrist, and that it was "probable and likely" that Petitioner's work activities as a carpenter for over 26 years contributed to his development of the disease. Further, the onset and progression of symptoms after the work accident suggested that the accident was a significant exacerbating factor in the development of his Kienbock's symptomatology. RX6, PX10.

Regarding treatment, Dr. Sudekum recommended radial shortening osteotomy, which involved removal of a three millimeter "wafer" of bone from the distal radial shaft and then fixation of the shortened radius with a plate and screws. This would equalize the forces or pressure across the wrist and redistribute pressure against the lunate bone more evenly between the radius and ulna. Dr. Sudekum noted the procedure would likely result in significant improvement for Petitioner, but that it was possible he would continue to experience significant wrist pain, stiffness, weakness, and progression of the disease. If that occurred, he would be a candidate for a more aggressive surgical procedure in the future. He disagreed with Dr. Young's recommendation for an arthroscopy, as he did not believe it would result in significant improvement. With regard to causation, Dr. Sudekum opined that although Petitioner had significant non-work related risk factors that predisposed him to Kienbock's disease, his work accident and his 26 years as a carpenter also contributed to the development and/or exacerbation of the disease. RX6, PX10.

On April 24, 2013, Petitioner underwent a left wrist radial shortening osteotomy, performed by Dr. Sudekum. He followed up with Dr. Sudekum on May 2, 2013, and reported mild to moderate pain in the wrist and distal forearm and slight numbness and tingling to the volar tip of the left thumb. Fluoroscopic x-rays revealed neutral radial ulnar variance and excellent alignment, fixation, and stability of the distal radius osteotomy. Petitioner was to remain casted for five more weeks and was allowed to resume light one-handed duty. He returned to Dr. Sudekum on June 6, 2013, and reported intermittent sharp and dull pain of the left wrist which increased if his arm and hand were hanging down in a dependent position. It was noted he had not returned to work as there was no one-handed duty available. The cast was removed and the incision was well healed. Fluoroscopic x-rays showed excellent alignment, fixation, stability, and healing of the distal radius shortening osteotomy. Petitioner was to begin occupational therapy and continue with light one-handed duty. PX10.

Petitioner presented to Herrin Hospital on June 14, 2013, for an initial occupational therapy evaluation. He had decreased range of motion and strength and he reported he was unable to complete household, work, and maintenance tasks. He had moderate to severe impairment with grasping and pinching with his left hand. Petitioner was educated in proper exercises and began treatment. He attended therapy sessions on June 14, 17, 19, 21, 24, 26, 28,

and July 1, 3, 5, 8, and 10, 2013. The progress summary of July 10, 2013, noted Petitioner continued to have pain at the base of his left thumb. It also noted, "Patient reports he now has increased pain in L (left) shoulder." The Arbitrator notes this is the first mention in any medical records of complaints with regard to Petitioner's left shoulder. PX11.

On July 22, 2013, Petitioner returned to Dr. Sudekum. He reported that the constant deep pain in his left wrist had resolved since surgery, but he continued to have occasional mild discomfort in the wrist and forearm. He believed his strength had continued to improve. Fluoroscopic x-rays of the wrist and forearm showed excellent alignment, fixation and stability and there was no evidence of increased collapse or worsening of the avascular necrosis. The Arbitrator notes Petitioner made no complaints with regard to his left shoulder. He was released to full, unrestricted duty beginning August 5, 2013. He followed up on October 21, 2013, and it was noted he was doing well. Fluoroscopic x-rays continued to show excellent alignment, fixation, and stability with no significant changes in the lunate bone. He again returned on February 25, 2014. He reported pain to his left wrist at times, which occurred a lot when he had his arms outstretched and was doing fine motor activities with his hands. He also complained of decreased grip strength, swelling after long days at work, numbness and tingling to his entire left hand with use and at night, inability to bear weight on his left palm, and occasional wrist pain that radiated into his left shoulder. On examination, range of motion was within normal limits and there was no obvious swelling. He was released from care at that time. PX10.

The next record of treatment is May 5, 2015, when Petitioner returned to Dr. Sudekum. It was noted he had quite a few complaints at that time. He reported continued intermittent pain and paresthesias of his left hand and wrist near the thumb, as well as tenderness to the radial forearm, made worse with twisting and lifting. Weight bearing and vibratory activities on the left hand and forearm caused pain to the forearm. He further reported that his left wrist popped, his hand cramped, and he had numbness and tingling of the left thumb, index, and middle fingers that kept him up at night and made fine motor activities difficult. His left hand would get cold and the only way to warm it up was to put it under warm running water. He complained of decreased strength as well. On examination, the surgical incision was well-healed. The hardware was barely palpable but was mildly tender to palpation. Petitioner had a strongly positive Tinel sign with tapping over the median nerve in the distal forearm, wrist, and palm. Fluoroscopic x-rays revealed excellent alignment, fixation, stability, and healing of the radial shortening osteotomy. The lunate bone appeared somewhat sclerotic but not significantly changed when compared to his preoperative x-rays. A nerve conduction study was also performed, which revealed borderline changes for the left median nerve indicative of possible nerve irritation secondary to scar tissue. Dr. Sudekum opined Petitioner had symptoms indicative of median neuropathy/carpal tunnel syndrome, most likely secondary to scar tissue in and around the carpal tunnel region and the area of the previous surgery, as well tendon adhesions in the same area. He recommended surgery, to include exploration and removal of hardware, open carpal tunnel release, and wrist and distal forearm flexor tenolysis. The Arbitrator notes that Dr. Sudekum referenced the ***right*** wrist and forearm when discussing the last two procedures, which the Arbitrator believes to be a scrivener's error, as the entirety of the remainder of his record refers to the ***left***. PX10.

The next record of treatment is February 1, 2016, when Petitioner presented to Dr. Nathan Mall at Regeneration Orthopedics. He gave a consistent history of the accident and his treatment to date. He reported that Dr. Sudekum had recently recommended surgery to remove the plate, due to persistent symptoms in the wrist and forearm, and he wanted a second opinion as he had "not been happy with the care at Dr. Sudekum's office". He indicated surgery had been recommended several months prior, but he had been trying to get his blood sugar under control. On examination, Petitioner had decreased fat pad in the volar aspect of the thumb, with decreased sensation but excellent movement in the thumb. He had pain to palpation over the volar plate of the radius and a mildly positive flexion compression test at the wrist. There was also pain to palpation over the scapholunate joint, the lunate itself, and the radiocarpal joint. The Arbitrator notes that Dr. Mall's report from this examination appears to be multi-pages; however, only the first page was submitted into evidence. As such, it is unknown what additional information may be contained on subsequent pages. A Work Status Report completed the same day lists diagnoses as left wrist painful hardware and lunate collapse, possible carpal tunnel, and lumbar disc herniation. Dr. Mall recommended surgical removal of the hardware, followed by physical therapy. Petitioner was instructed to work light duty in the interim. PX12.

On February 11, 2016, Petitioner underwent surgery by Dr. Mall, consisting of removal of hardware in the left wrist and left carpal tunnel release. PX14. He followed up with Dr. Mall on February 23 and reported he was doing very well with only minimal symptoms. He noted he could "feel his thumb again for the first time in three years". On examination, he had good sensation in his thumb, index, and long fingers. He was to begin physical therapy for range of motion and strengthening. PX12.

Petitioner presented to Marshall Browning Hospital on February 29, 2016, for an initial physical therapy evaluation, with noted complaints to his left wrist and hand post carpal tunnel release and plate removal. He attended therapy on March 3, 7, 10, 14, and 16. PX3.

On March 22, 2016, Petitioner returned to Dr. Mall, and reported he was doing well but had some residual numbness in the thumb. The pain and numbness in the wrist had "substantially improved" following surgery. Dr. Mall's note goes on to state, *"He has been complaining of some left shoulder pain this entire time as he states that he has told multiple physicians about this. However, given the severity of his left hand and wrist complaints, these took precedence previously. As he is improving from his left wrist complaints, I feel it is warranted to go ahead and start addressing some of the shoulder complaints at this time."* On examination, Petitioner's strength and grip were improving and his range of motion was excellent. With regard to the shoulder, he had minimal pain to palpation over the AC joint, negative O'Brien's test, mild pain to palpation and very mild loss of strength in supraspinatus testing. Dr. Mall noted some continued numbness in the pad of the thumb and decreased fat in the area. He indicated if this continued to be a problem Petitioner could possibly see another hand specialist who had experience with fat grafting. With regard to the wrist, Dr. Mall indicated there was only minimal shortening in the first surgery and he indicated the possibility of a repeat radial shortening or proximal row corpectomy if problems continued. As to the shoulder, he recommended a cortisone injection into the subacromial space and physical therapy for rotator cuff strengthening. Petitioner was allowed to return to full duty work. PX12.

On April 6, 2016, Petitioner underwent a physical therapy reassessment, at which time an additional diagnosis of left rotator cuff tendonitis was noted. Therapy continued, and on April 8 he reported his hand and shoulder felt great, but he complained of back pain. At his April 12 session he was able to complete all of his exercises. On May 2, 2016, he reported he saw a doctor for his back pain and received steroid injections in his back on April 26. His doctor planned to schedule back surgery in September. He reported his left shoulder was feeling much better. The Arbitrator notes this was the final physical therapy note submitted. PX3.

Petitioner returned to Dr. Mall on May 10, 2016, and reported he was overall fairly happy with the results of his left wrist surgeries. He was able to do more things after the most recent surgery than he had done in the three years since his accident. With regard to the left shoulder, he reported the injection helped substantially and he had only mild symptoms. On exam, he had good range of motion of the left wrist, with some pain to palpation over the lunate. The left shoulder had some pain to palpation over the AC joint and strength was normal. Dr. Mall gave Petitioner a full release, but opined that he would likely require additional left wrist surgery, as he continued to have pain to palpation over the lunate. He noted the radial shortening was minimal and that it was likely Petitioner would have persistent symptoms with his wrist when he started loading the wrist with work. Petitioner advised he wanted to try and get through the summer months, and hopefully a couple of years, before having another surgery such as a fusion. Dr. Mall agreed that was a reasonable approach, as the surgery was one "that should only be performed after failure of all conservative efforts". The Arbitrator notes this was the final treatment record submitted. PX12.

CONCLUSIONS OF LAW

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

The parties stipulated that on July 20, 2012, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in an injury to his left thumb, wrist, and forearm. The parties disputed whether the accident caused an injury to Petitioner's left shoulder, the causal relationship of his current shoulder condition, and the medical costs associated with treatment of the shoulder.

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:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2. *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he injured his left shoulder in the accident of July 20, 2012. In so concluding, the Arbitrator finds significant that the medical records are void of any reference whatsoever to shoulder pain until July 10, 2013, almost exactly one year after the accident. Petitioner testified, "I told every doctor I saw through the course of everything that I had shoulder pain, and I told them at the hospital the day that it happened." He made the same assertion to Dr. Mall on March 22, 2016. However, none of the medical records in evidence corroborate this assertion.

The first mention of any shoulder pain is the physical therapy note of July 10, 2013, which stated Petitioner reported he ***now*** had increased pain his left shoulder. There is no further explanation or detail with regard to the pain, including how or when it started. Petitioner then saw Dr. Sudekum on July 22 and October 21, 2013, and on neither occasion did he mention having shoulder pain. It is not until February 25, 2014, that he again references the shoulder, when he reported that at times his wrist pain *radiated into* his left shoulder. There was no reference to pain originating in the shoulder itself. He then saw Dr. Sudekum on May 5, 2015, Dr. Mall on February 1 and February 23, 2016, and physical therapists on March 3, 7, 10, 14, and 16, 2016, and on no occasion did he reference complaints regarding his left shoulder. However, when he saw Dr. Mall on March 22, 2016, he reported he had been complaining of shoulder pain "this entire time" and had told "multiple physicians" about this. The record simply does not support this assertion. In fact, between the date of his accident and the physical therapy note of July 10, 2013, Petitioner saw no less than nine medical providers, none of whom recorded any complaint with regard to his left shoulder. The Arbitrator finds Petitioner not credible in his testimony that he told the hospital and every doctor about his shoulder complaints, and his inference that they just did not make a record of it.

When evaluated in its entirety, the record does not support a finding that Petitioner sustained an injury to his left shoulder in the accident of July 20, 2012, and Petitioner has failed to prove same.

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:

In light of the Arbitrator's findings above with respect to issue (C), the Arbitrator finds Petitioner's current condition of ill-being with regard to his left shoulder is not related to his accident of July 20, 2012.

The parties stipulated and the Arbitrator finds that Petitioner's current condition of ill-being with regard to his left thumb, wrist, and forearm is related to his accident of July 20, 2012.

In support of the Arbitrator's decision relation 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:

The parties stipulated that Respondent had paid all medical bills related to Petitioner's left thumb, wrist, and forearm. The only bills in dispute were those related to treatment for the left shoulder.

In light of the Arbitrator's findings above with respect to issue (C), the Arbitrator finds that Respondent is not liable for medical bills related to Petitioner's left shoulder as set forth in Petitioner's Exhibit 1.

Specifically, with regard to bills from Dr. Mall, as a practical matter his treatment was primarily for the left thumb, wrist, and forearm and it appears the bills cannot be separated out by body part treated. However, on March 22, 2016, in addition to the office visit, Dr. Mall administered an injection into Petitioner's left shoulder and Respondent is not liable for the charges associated with this injection. Specifically, the Arbitrator declines to award the charge of $263.00 (CPT Code 20610-LT) and the charge of $24.00 (CPT Code J1030).

Likewise with regard to bills from Marshall Browning Hospital, the physical therapy performed from April 6, 2016, through May 2, 2016, was primarily for the left thumb, wrist, and forearm following Petitioner's surgery of February 11, 2016. It appears the bills cannot be separated out by body part treated and for that reason the Arbitrator awards all of those bills, and Respondent is liable for same.

The Arbitrator finds that Respondent is liable for all other outstanding medical bills, if any, as set forth in Petitioner's Exhibit 1, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act, with the following exceptions.

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

1. Dr. Anthony Sudekum/Midwest Special Surgery $409.01
    1) May 2, 2013 $60.00
    2) June 6, 2013 $60.00
    3) July 22, 2013 $60.00
    4) October 21, 2013 $60.00
    5) July 3, 2014 $49.78
    6) February 6, 2015 $27.24
    7) May 5, 2015 $60.00
    8) June 23, 2015 $31.99
2. Dr. Nathan Mall/Regeneration Orthopedics $144.00
    1) February 2, 2016 $36.00
    2) February 23, 2016 $36.00
    3) March 22, 2016 $36.00
    4) May 10, 2016 $36.00

Respondent shall receive credit for amounts 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 (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section 8.1b 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 this accident was after the effective date of Section 8.1b of the Act, neither party offered into evidence a reported level of impairment pursuant to subsection (a). As such, the Arbitrator gives no weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Carpenter Foreman at the time of the accident and that he was able to return to work in his prior capacity without restrictions as a result of said injury. The Arbitrator notes the physical nature of Petitioner's occupation, which is hand intensive and involves use of heavy and/or vibratory tools. Petitioner testified his injury substantially impacted his ability to do his work and that he tries to avoid heavy activities, especially the vibratory activities, as they cause extreme pain. 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 49 years old at the time of the accident. He has returned to his prior position without restrictions. Given his age, he can be expected to continue working with the ill effects of his injury for several more years. Over time his condition could improve, stay the same, or get worse. The Arbitrator places a great amount of 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 change in pay. Neither party offered evidence to show that Petitioner's future earning capacity has been impacted. However, the Arbitrator notes that both Dr. Sudekum and Dr. Mall opined that Petitioner may require additional surgery of a corpectomy or fusion in the near 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 comminuted fracture of his left thumb, radial injury of the left wrist with traumatic acquisition of Kienbock's disease, and traumatic carpal tunnel syndrome. He underwent two surgeries consisting of three procedures, a radial osteotomy, removal of the hardware, and left carpal tunnel release. His subjective complaints are well-documented in his medical records throughout his treatment. He testified he continues to have constant soreness in his left arm, thumb, and hand. He lost 42% of the thumb pad and has no feeling in that area. He also testified he has decreased grip and strength. The physical therapy Discharge Summary of May 25, 2016, documents Petitioner's range of motion and grasp were less on the left than on the right. Dr. Mall's note following Petitioner's final visit of May 10, 2016, documents he had good range of motion of the left wrist but continued to have pain to

palpation over the lunate. Although Dr. Mall released him from care without restrictions at that time, he believed Petitioner would likely require additional surgery with regard to his left wrist, as he continued to have pain and symptoms over the lunate. Dr. Sudekum had opined similarly. He further believed Petitioner would have persistent symptoms with his wrist when the wrist became loaded by his return to full work duties. 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 issues 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 28% loss of use of the left hand (57.4 weeks) pursuant to Section 8(e) of the Act.

The parties stipulated that Petitioner's earnings during the year preceding the injury were $68,042.70. The Arbitrator notes, however, that the average weekly wage listed on the Request for Hearing (Arbitrator's Exhibit 1) is erroneous. Respondent's Exhibit 1 documents Petitioner's wages, as outlined above, and also lists the calculation of the average weekly wage of $1,308.51 and the temporary total disability rate of $872.78. The Request for Hearing erroneously listed the average weekly wage as $872.78, which is actually the TTD rate, rather than listing the actual wage. The Arbitrator finds Petitioner's average weekly wage is $1,308.51 and his permanent partial disability rate is $712.55, which is the statutory maximum rate applicable to his date of accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Apolonio Garcia,

Petitioner,

vs. NO: 13 WC 28267

Eddie's Landscaping & Maintenance,

Respondent.

18IWCC0422

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 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 7, 2017, is hereby affirmed and adopted.

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

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

18IWCC0422

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: JUL 5 - 2018
o062818
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

GARCIA, APOLONIO
Employee/Petitioner

Case# **13WC028267**

EDDIE'S LANDSCAPING & MAINTENANCE
Employer/Respondent

18IWCC0422

On 7/7/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN FISHMAN BENDER ET AL
DAVID Z FEUER
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
MARGARET G McGARRY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

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

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

Apolonio Garcia
Employee/Petitioner

v.

Eddie's Landscaping & Maintenance
Employer/Respondent

Case # 13 WC 28267

Consolidated cases: N/A

18IWCC0422

An *Application for Adjustment 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 **Wheaton** on **May 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0422

FINDINGS

On the date of accident, July 26, 2013, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $28,600.00; the average weekly wage was $550.00.

On the date of accident, Petitioner was 46 years of age, *married* with no dependent children.

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

Respondent shall be given a credit of $20,166.85 for TTD[1], $550.02 for TPD[2], $0 for maintenance, and $0 for other benefits, for a total credit of $20,666.87.

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

ORDER

As explained in the Arbitration Decision Addendum, Petitioner has failed to establish a causal connection between his current condition of ill-being in the lumbar spine beyond that opined by Respondent's Section 12 examiner, Dr. Goldberg, and accident at work. Petitioner's claim for prospective medical treatment in the form of a lumbar surgery as recommended by Dr. Koutsky 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

July 6, 2017
Date

ICArbDec19(b) p. 2

JUL 7 - 2017

[1] As stipulated by the parties, Petitioner is entitled to temporary total disability benefits from July 26, 2013 to August 15, 2014 at $366.67. AX1.

[2] As stipulated by the parties, Petitioner is entitled to temporary partial disability benefits from August 16, 2014 to September 5, 2014 at $183.34. AX1.

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

Apolonio Garcia
Employee/Petitioner

v.

Eddie's Landscaping & Maintenance
Employer/Respondent

Case # **13** WC **28267**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include causal connection relative to the lumbar spine and whether Petitioner is entitled to prospective medical care in the form of a lumbar fusion surgery as ordered by Dr. Koutsky. Arbitrator's Exhibit[3] ("AX") 1. The parties have stipulated to all other issues. AX1.

Employment & Background

Apolonio Garcia (Petitioner) testified that he was employed by Eddie's Landscaping & Maintenance (Respondent). Petitioner was employed as a grass-cutter. On cross examination, Petitioner testified that he was working as a foreman performing seasonal work.

On July 26, 2013, Petitioner testified that he had an accident. The accident is not in dispute. AX1. Petitioner explained that he was standing on the side of the road sitting on a small lawnmower tractor when it was hit by the trailer of a truck. Petitioner testified that after the impact he fell to the side of the lawnmower on the ground and stayed there on his side until the ambulance came. Petitioner noticed a sensation of "lightning" and felt dizzy. Petitioner testified that he could not move, felt dizzy and did not know what happened. Petitioner was taken by ambulance to Elmhurst Hospital.

Petitioner testified that he first felt low back pain on the date of accident. He testified that he did not have low back pain before his accident.

Medical Treatment

The medical records reflect that Petitioner presented at the emergency department of Elmhurst Memorial Hospital on July 26, 2013. PX7. During triage, a nurse noted Petitioner's history that "PT WAS DRIVING LAWNMOWER AND HIT A MOVING TRAILER (ATTACHED TO MOVING TRUCK). PT WAS THROWN FROM LAWNMOWER ONTO THE STREET. PT WITH R ANKLE PAIN AND DEFORMITY AND R KNEE PAIN AND LOW BACK PAIN. PT DENIES LOC." *Id.* Petitioner underwent x-rays and was examined by Daniel Belmont, M.D. (Dr. Belmont). *Id.* Regarding the low back, Dr. Belmont noted tenderness to the midline of the lumbar spine from L2 through the sacrum. *Id.* Petitioner also had tenderness to palpation of the distal right leg through the ankle. *Id.* A long-leg splint was applied to the right leg. *Id.* Dr. Belmont diagnosed Petitioner with a Maisonneuve fracture of the right leg, back contusion, hand contusion, and hip

[3] 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. Ex. _)."

contusion. *Id.* Petitioner was referred to John Nikoleit, M.D. (Dr. Nikoleit) for orthopedic follow up and instructed to return to the emergency department if numbness or pain increased. *Id.*

Petitioner saw Dr. Nikoleit and underwent a right ankle syndesmosis repair surgery for his right ankle Maisonneuve fracture on August 1, 2013. PX2. He continued to follow up with Dr. Nikoleit regarding the right ankle. *Id.*

On October 13, 2013, Petitioner presented at Silver Cross Hospital complaining of spasm in the right leg with pain and tingling from the right thigh down to the foot over the last two months. PX1. Petitioner underwent a CT scan of the lumbar spine for "PAIN IN THE HIP DOWN TO THE ANKLE. STATUSPOST SURGERY TO THE ANKLE." *Id.* The interpreting radiologist found mild degenerative disc disease and degenerative joint disease at various levels. *Id.* He was diagnosed with right lumbosacral radiculopathy and discharged. *Id.* On cross examination, Petitioner testified that he went many times for the pain in his back to Silver Cross Hospital.

On December 17, 2013, Dr. Nikoleit's records document a telephone conversation with Petitioner's daughter in which she expressed concern about her father's persistent pain in the leg that radiates to his waist area during physical therapy. PX2. She inquired whether there might be tests to determine the source of Petitioner's pain. *Id.* Dr. Nikoleit's office scheduled a follow up visit and Petitioner presented the following day. *Id.* Petitioner reported "right leg pain and weakness as well as back pain has started now." *Id.* Dr. Nikoleit noted that he had previously discussed an MRI which was cancelled after Petitioner's EMG showed a distal neuropathy, but with the continued back pain, he ordered a lumbar MRI to assess whether there was nerve impingement. *Id.*

Petitioner continued to complain of back problems to Dr. Nikoleit. PX2. On December 30, 2013, Petitioner reported some back problems that radiated down his right leg. *Id.*

On January 14, 2014, Dr. Nikoleit's records reflect a telephone conversation where Petitioner reported that he went to the emergency room at Silver Cross hospital for pain in his leg and in his back. PX2. Petitioner also reported that his right foot became purple, he became dizzy, and felt like he was going to pass out. *Id.* He underwent an EKG, that was normal. *Id.*

Petitioner returned to Dr. Nikoleit on January 21, 2014 reporting pain radiating from the back down the leg. *Id.* Dr. Nikoleit noted that Petitioner's MRI[4] showed some bulging discs, but no nerve root impingement. *Id.* He ordered physical therapy for the lumbar spine. *Id.* On February 14, 2014, Petitioner's daughter called Dr. Nikoleit's office reporting that Petitioner was suffering from anxiety and requesting medication. *Id.*

On February 18, 2014, Petitioner reported pain in the back that radiated down the right leg. PX2. Dr. Nikoleit ordered additional physical therapy for the lumbar spine and strengthening of the right leg. *Id.* As of March 18, 2014, Petitioner reported pain that radiated into the right gluteal region with minimal improvement from physical therapy. *Id.* Dr. Nikoleit noted a "questionable straight leg raise" on physical examination and diagnosed Petitioner with lumbar radiculopathy and a right ankle fracture with foot drop. *Id.* He referred Petitioner to the pain clinic and Dr. Karim Yumez (Dr. Yumez) for evaluation of the anxiety. *Id.*

On April 18, 2014, Petitioner reported back pain that radiating into the right leg and neck problems for the first time that radiated into the right shoulder. *Id.* Dr. Nikoleit diagnosed Petitioner with a right ankle fracture with peroneal weakness and ordered continued physical therapy. *Id.* Petitioner also underwent an EMG/NCV on

[4] The MRI report is not contained in the records, but was interpreted by Dr. Nikoleit and other examining physicians.

May 6, 2014. RX2. The physician administering the test found that Petitioner showed improving right peroneal neuropathy. *Id.*

On May 16, 2014, Petitioner reported a lot of back pain that radiated into the right hip and weakness in the right ankle. *Id.* Dr. Nikoleit noted that approval for the pain clinic referral was not yet provided. *Id.* He also anticipated maximum medical improvement regarding the right ankle in three months. *Id.* On June 13, 2014, Petitioner continued to report low back pain. *Id.* Dr. Nikoleit diagnosed Petitioner with low back pain and a healing right ankle fracture and peroneal nerve injury. *Id.* He reiterated his referral to the pain clinic for evaluation. *Id.*

On June 23, 2014, Petitioner began work conditioning at Brightmore Physical Therapy. PX5. The initial evaluation report noted Petitioner's complaints of lumbar pain. *Id.* He demonstrated decreased range of motion and decreased strength in the right ankle as well as an antalgic gait. *Id.* However, Petitioner showed normal strength in the lumbar spine. *Id.* Work conditioning was recommended five times per week for four weeks. *Id.*

On July 11, 2014, Dr. Nikoleit noted Petitioner's ongoing report of low back pain and referred him to Dr. Koutsky, a spine surgeon, for evaluation. *Id.*

Petitioner then saw Kevin Koutsky, M.D. (Dr. Koutsky) for the first time at Elmhurst Orthopedics on July 25, 2014. PX2. Dr. Koutsky noted the following history in pertinent part:

> A 47-year-old male who is here today for evaluation of his lower back pain, radiating to the right lower extremity, into the buttock and thigh. He denies any specific numbness or tingling. He does admit to some weakness in his right ankle, but states this is getting better. ... His symptoms began initially on July 26, 2013. He was working for [Respondent] and was hit by a landscaping trailer from another company, which hopped the curb then dragged him for a distance. He was taken via ambulance to Elmhurst Hospital. He sustained a right ankle fracture as well as a common peroneal injury in the right lower extremity. He has been treating with Dr. Nikoleit, who fixed his ankle. All the while, his back pain has remained the same. He has been in therapy for both his ankle and back. Dr. Nikoleit did work him up with an MRI scan of the lumbar spine, which revealed evidence of right-sided disk protrusion. Dr. Nikoleit has been recommending epidural injections; however, he is still awaiting authorization. He is here today for orthopedic spine evaluation.

Id. On physical examination, Dr. Koutsky noted that Petitioner had a positive straight leg raise test that recreated right leg pain as well as paralumbar spine tenderness. *Id.* Dr. Koutsky reviewed Petitioner's October 29, 2013 EMG, which showed common peroneal neuropathy. *Id.* He also read Petitioner's January 9, 2014 lumbar MRI to show evidence of multiple level spondylotic changes, a right-sided disc protrusion/annular tear at L4-L5, and some mild multifactorial stenosis at L3-L4 and L4-L5. *Id.* Dr. Koutsky diagnosed Petitioner with lumbar radiculopathy and ordered a pain clinic evaluation for a lumbar epidural injection, a TENS unit, and prescription medications. *Id.*

On August 7, 2014, Petitioner completed work conditioning. PX5. The discharge note indicates that Petitioner met all the goals of therapy, which included the right foot and low back, and that he demonstrated the ability to work in the heavy physical demand level. *Id.*

From August 29, 2014 through January 19, 2015, Dr. Koutsky's records note that Petitioner was waiting for authorization of the epidural steroid injection. PX2. Dr. Koutsky continued to diagnose Petitioner with lumbar radiculopathy. *Id.* In the interim, on December 26, 2014, Dr. Koutsky recommended physical therapy and an

injection and referred Petitioner for a third lower extremity EMG/NCV test. PX3.

Respondent's First Section 12 Examination – Dr. Goldberg

On January 7, 2015, Petitioner was evaluated by Edward Goldberg, M.D. (Dr. Goldberg) of Midwest Orthopedics at Rush at Respondent's request. RX1 (Dep. Ex. 2). Dr. Goldberg reviewed Petitioner's medical treatment records and took the following history from Petitioner in pertinent part:

> Mr. Garcia was seen in the office today … regarding his lumbar spine. His daughter accompanied him and spoke outstanding English. The patient is a 47-year-old male who reports injuring himself while employed as a landscaper on 07/26/2013. He states he was putting a lawnmower into a trailer and he was struck by a pickup truck he reports that he sustained an ankle fracture and had surgery. Hume status at the time of the accident, he had low back pain, but all the primary problem is in the ankle. He states he was subsequently treated in a cast and used crutches. He reports that he did have back pain at the time of the accident and then when using crutches, it became increasingly severe. He states he underwent physical therapy and work conditioning. He did return to work full duty in 08/2014. He states the surgery was performed by Dr. Nikoleit.
>
> The patient reports that he attempted to return to work full duty and was able to do so only for a couple of weeks. He reports that he is under the care of Dr. Koutsky and had one lumbar epidural injection with no significant improvement.
>
> He complains of low back pain aggravated with bending, twisting, and prolonged sitting. He complained of pain along the lateral malleolus of his right ankle and also the proximal right fibular head. Occasionally, at the end of the day, he feels the pain all the way from his right ankle up to his neck. He denies prior lumbar problems.

RX1 (Dep. Ex. 2). Upon physical examination, Petitioner reported some low back pain with flexion and extension. *Id.* He demonstrated negative straight leg rising bilaterally and no muscle atrophy or long tract findings in the lower extremities. *Id.* Petitioner was tenderness to palpation with positive Tinel's at the fibular neck consistent with irritation of the peroneal nerve. *Id.* Petitioner was also tender at the lateral malleolus. *Id.*

Dr. Goldberg diagnosed Petitioner with a lumbar strain and/or aggravation of some lumbar degenerative disc disease. RX1 (Dep. Ex. 2). He opined that it was "possible that his back complaints are due to the accident. He reports he did have back pain after the accident on the date of injury, but all focus was on the right ankle. He states that during his rehabilitation including crutches his back pain increased." *Id.* However, Dr. Goldberg further indicated that Petitioner's only abnormality on physical examination was his positive Tinel's, consistent with a peroneal problem, and he opined that Petitioner did not have lumbar radiculopathy because both of Petitioner's EMG's were negative. *Id.* He also indicated that Petitioner's complaints of right ankle pain up to his neck were not consistent with lumbar radiculopathy. *Id.*

Ultimately, Dr. Goldberg placed Petitioner at maximum medical improvement, opined that he did not require any additional treatment related to the lumbar spine, and that he could return to full duty work given his completion of work conditioning. *Id.*

Continued Medical Treatment

On January 22, 2015, Petitioner underwent an EMG/NCV as ordered. *Id.* The physician administering the test

found mild irritability present on EMG needle insertion study suggestive of mild right L4-5 nerve root irritation. *Id.* On January 26, 2015, Dr. Koutsky noted that Petitioner's EMG/NCV showed evidence of right L4-L5 nerve root irritation. PX2; PX3.

Petitioner continued to see Dr. Koutsky or a nurse in his office through the spring of 2015. PX3. Dr. Koutsky continued to recommend a pain management consultation for an epidural steroid injection as well as physical therapy throughout this period. *Id.* On July 20, 2015, August 24, 2015, and September 28, 2015 Dr. Koutsky administered a trigger point injections to Petitioner's right paralumbar region. *Id.*

In the interim, Petitioner presented for his pain management[5] evaluation with Rajesh Patel, M.D. (Dr. Patel) on September 15, 2015. PX6. Dr. Patel noted the following history in pertinent part:

> Neck pain noted. On a scale from 1 to 10, the pain is rated a 6 in intensity. The location is primarily in the cervical spine and in the lumbar spine. The pain radiates to the right neck, right shoulder, mid-scapular right, right upper arm, and right foot. He characterizes it as constant, moderate in intensity, aching, dull, sharp, and throbbing. This is a chronic problem, with essentially constant pain. He states that the current episode of pain started after the injury, dated 7/26/2013. The event which precipitated this pain was Work injury an employee that was driving a lawn mo[w]emergency room hit him and he fell backward.. This occurred at work. Aggravating factors contributing to the pain may be bending over, job-related repetitive lifting back strain, lifting, prolonged positions, pushing a heavy object, sitting, standing, and throwing. Associated symptoms include numbness in the right lower leg and weakness of the right lower leg. He denies urinary and bowel incontinence.. Medications include ibuprofen. He notes some pain relief with massage, heat, muscle relaxants, medications, and physical therapy. The pain worsens with activity, walking, and House w[]ork, getting dressed, daily activities, weather changes, laying down.. The patient's functional limitations from this pain include: bending over, prolonged positions, pulling a load, standing, walking, household task, and dressing one self. Previous interventional therapy included: lumbar ESI 11/2014 with relief x 3 months. EMG demonstrates right L4-5 nerve root irritation MRI findings and imaging reviewed in detail with patient. Moderate disc bulge at L4-5 with annular fissure.
>
> The patient has tried conservative therapy such as a modification of activities, a home exercise regimen for 2 months, oral medications touches muscle relaxants/narcotics/NSAIDS for at least 4 wks w/out relief, physical therapy and/or chiropractic therapy for PT x 8 wks, the patient reports and exhibits a decreased functionality and QOL, the pain is incapacitating and has a difficult time with their ADLs.

Id. Dr. Patel diagnosed Petitioner with neck pain, low back pain, and lumbar radiculitis. *Id.* He also recommended, and administered, a lumbar right transforaminal epidural steroid injection at L4-5. *Id.*

Petitioner returned to Dr. Patel on October 20, 2015 and received a second lumbar transforaminal epidural steroid injection at L4-5. PX6. On November 3, 2015, Petitioner received a third injection. *Id.* On November 17, 2015, Petitioner received a fourth injection. *Id.*

On December 3, 2015, Petitioner reported pain in the back and legs. PX3. Dr. Koutsky diagnosed Petitioner with bilateral L4-L5 and L5-S1 radiculopathy, stenosis, and probable discogenic pain. *Id.* He recommended a lumbar discogram, referred Petitioner for a neurosurgical evaluation, and discussed surgical intervention including a decompression and fusion. *Id.*

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[5] Dr. Patel's records reflect that Petitioner's substance abuse history is "NEGATIVE[,]" however each progress note also redacts information below the notation as well as one prior medical history diagnosis. PX6.

On December 22, 2015, Petitioner returned to Dr. Patel. PX6. He noted that Petitioner's last injection provided 90% relief over one week and that Petitioner was managing his pain with valium. *Id.*

On January 7, 2016, Dr. Koutsky noted Petitioner's visit with Dr. Dixon who agreed that Petitioner was a candidate for a decompression and stabilization with instrumentation surgery. PX3. Dr. Koutsky continued to recommend the surgery through May 26, 2016. *Id.*

On January 19, 2016, Dr. Patel noted that Petitioner was to wean off the valium over the next four weeks, and noted that they awaited approval of the recommended discogram. PX6.

Respondent's Second Section 12 Examination – Dr. Goldberg

On April 15, 2016, Petitioner was evaluated a second time by Dr. Goldberg at Respondent's request. RX1 (Dep. Ex. 3). Dr. Goldberg reviewed updated medical records, performed a physical examination, and took additional history from Petitioner. *Id.*

Dr. Goldberg maintained his opinion that Petitioner sustained a lumber strain as a result of the accident at work. RX1 (Dep. Ex. 3). He reiterated that Petitioner was at maximum medical improvement, that he could work full duty, and that the epidural injections were not required. *Id.* Furthermore, Dr. Goldberg opined that Petitioner did not require surgery. *Id.*

Deposition Testimony – Dr. Goldberg

On October 10, 2016, Respondent called Dr. Goldberg as a witness and he gave testimony at an evidence deposition regarding Petitioner's medical treatment and the opinions contained in his reports. RX1. Dr. Goldberg is an orthopedic surgeon. RX1 at 4-5; RX1 (Dep. Ex. 1).

Dr. Goldberg disagreed with Dr. Koutsky's reading of petitioner's 2013 MRI films. RX1 at 7-9. He indicated that the MRI showed some age appropriate disc degeneration at L2-3, L3-4, and L4-5, and testified that petitioner did not have herniation at L4-5, but rather a small tear in the outer annulus at that level meaning petitioner had no herniated disc material or nerve compression. RX1 at 9-10. With regard to the October 29, 2013 and May 6, 2014 EMG/NCV reports, Dr. Goldberg found evidence of peroneal neuropathy and opined that neither EMG/NCV revealed lumbar radiculopathy. RX1 at 11.

Dr. Goldberg explained that he found no evidence of neurological deficits from a spinal point of view that related to the lumbar spine in etiology. RX1 at 11. The only abnormalities found on physical examination were the weakness in the tibialis anterior, or ankle dorsiflexion, and the positive Tinel's at the outside of the fibular neck where the peroneal nerve is located. *Id.* Dr. Goldberg testified that these findings were compatible with the peroneal neuropathy evidenced in the October 2013 and May 2014 EMG/NCV tests and were not related to the lumbar spine in etiology. RX1 at 12.

Dr. Goldberg maintained his opinion that Petitioner sustained a lumbar strain at the time of the work accident with no objective evidence of lumbar radiculopathy relying specifically on the two negative EMG/NCV tests and the lumbar MRI, which he indicated showed no nerve compression in the lumbar spine. RX1 at 12-13. He also maintained his opinions that Petitioner required no additional treatment for the lumbar spine, that Petitioner had reached maximum medical improvement, and that he could return to full duty work. RX1 at 15-18.

On cross examination, Dr. Goldberg acknowledged that Petitioner sustained a lumbar spine injury, but his pain could not be substantiated at the time of his second evaluation. RX1 at 19. He also acknowledged that Petitioner had a positive Tinel's sign, which indicated irritability, and could have been causing some of Petitioner's leg symptoms. *Id.* Dr. Goldberg maintained that there was no evidence to suggest that Petitioner required a fusion surgery as recommended by Dr. Koutsky. RX1 at 20-21. He noted that Petitioner had no spinal instability, evidence of a disc herniation on the MRI, and very good relief in response to trigger point injections, which would go against performing surgery. *Id.*

Continued Medical Treatment

On December 5, 2016, Petitioner underwent another lumbar MRI. PX4. The interpreting radiologist noted a small central-to-right paracentral disc herniation at L4-5 showing slight increase in size and impact when compared to January 9, 2014 as well as scoliosis and multilevel degenerative changes of a very mild degree, which was stable. *Id.*

On December 14, 2016, Petitioner underwent another EMG/NCV. PX4. The technician noted electrical evidence of bilateral lumbar radiculopathy with most prominent findings at L4-5. *Id.*

On February 9, 2017, Dr. Koutsky diagnosed Petitioner with bilateral L4-5 and L5-S1 radiculopathy. PX4. He indicated that Petitioner continued "to suffer from lumbar radiculopathy after his work-related injury." *Id.* He maintained his order for a lumbar discogram as well as surgery. *Id.*

Additional Information

Petitioner testified that he sometimes works 3-4 hours in one day five days per week. But sometimes he stops because he gets dizzy. Petitioner does not take medication for high blood pressure. Petitioner testified that when he gets pain, that is when the dizziness starts. Petitioner testified that he cuts the grass, spreads mulch, cleans, and telling people what to do.

Petitioner testified that he takes medications, sometimes. He takes the medications when he feels bad and he gets dizzy. Petitioner testified that he takes pain pills when he gets bad, which happens at least once a day. Petitioner also takes muscle relaxers. Petitioner only takes pain medications when he starts to get dizzy. Petitioner testified that the pain medications are prescribed by his doctor, which he gets refilled once per month.

Petitioner testified that he wishes to undergo the surgery that Dr. Koutsky recommended. Petitioner testified that he feels very dizzy and stiff and he feels numbness in his right leg. Petitioner testified that his symptoms increase when he does heavier work. Petitioner testified that the right lower back. None of these symptoms before his accident at work. Petitioner testified that he feels bad and he wants to heal.

On cross examination, Petitioner testified that he went to Silver Cross Hospital on various occasions. On November 15, 2014, Petitioner denied reporting that he was able to paint his whole house and testified that he paid someone to do this.

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:

Petitioner has failed to establish a causal connection between his current condition of ill-being in the low back and accident at work. In so concluding, the Arbitrator notes that Petitioner's EMG/NCV tests showed no radiculopathy and Petitioner's treating physician, Dr. Nikoleit, reviewed Petitioner's lumbar MRI in which he noted no evidence of nerve root impingement, which is consistent with the MRI interpretation of Respondent's Section 12 examiner, Dr. Goldberg. Thus, in light of the foregoing, the Arbitrator finds the opinions of Dr. Goldberg to be more persuasive than those of Dr. Koutsky in this case and adopts the opinions of Dr. Goldberg. Given the totality of the medical evidence, the Arbitrator finds that Petitioner has reached maximum medical improvement and he has failed to establish a causal connection between his current low back condition or the alleged radicular symptoms and the July 26, 2013 work accident.

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 not causally related to his accident at work as claimed. Thus, Petitioner's claim for prospective medical treatment in the form of a lumbar surgery as recommended by Dr. Koutsky is neither reasonable nor necessary to alleviate Petitioner of the effects of his injury at work and is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LADREAMA BURDETT,

Petitioner,

vs. NO: 13 WC 11012

SOUTHERN ILLINOIS UNIVERSITY,

Respondent.

18IWCC0423

DECISION AND OPINION ON REVIEW

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

Findings of Fact and Conclusions of Law

The Commission agrees with the Arbitrator's Statement of Facts. The Commission agrees with the Arbitrator that Petitioner's testimony was not credible with regard to the vocational rehabilitation process. (ArbDec, p. 15) The Commission finds Petitioner's testimony that she was not aware she had to follow-up on job applications but thought she "only had to apply" for jobs is one of several mendacious claims. Given Petitioner's prior job skills and certifications, the Commission also finds Petitioner's testimony that she had difficulty during her basic skills computer class despite her vocational counselor's help, incredible.

The Commission further finds Petitioner's testimony to be fraught with inconsistencies. Although Petitioner claimed to have completed tasks provided by her vocational counselor ninety-eight percent of the time, she testified she "dedicated two to three hours per week" to her job search. Petitioner also initially testified that she had mostly below average grades in high school,

however, then conceded she received "C" grades as well and she had reported to Respondent's counselor she was an average student.

The Commission finds the Respondent's vocational counselor, Helen Weber, who worked with Petitioner for eighteen months, to be more credible than either Petitioner's first vocational counselor who had one phone conference with Petitioner and her attorney and more credible than Petitioner's second counselor, Kari Stafseth who reviewed the Respondent's vocational counselor's reports and arrived at her conclusions based thereon. Ms. Stafseth's addendum report alleges Petitioner had challenges to returning to a viable stable labor market, however, the counselor admitted to having only one other case in Southern Illinois whereas Ms. Weber practices in Southern Illinois. In addition, while the Petitioner's counselor noted Petitioner had no aptitude testing, the Commission finds Petitioner graduated from high school with no reported difficulties in reading, spelling or math and she holds a standard Illinois driver's license and previously had a Class "B" driver's license.

The Petitioner also testified she initially did all job applications via her mobile phone, however, then testified she had agreed with Ms. Weber she could use the library computer. Petitioner could not explain the reason that Ms. Weber could not confirm her applications although they were allegedly completed and submitted via her iPhone mobile device. The Petitioner was given the opportunity to obtain computer skills and given her general education high school background and certifications obtained at the Operating Engineers, the Commission is not persuaded Petitioner cannot learn basic computer skills. As such, the Commission finds the Petitioner failed to make good faith efforts to cooperate in the rehabilitation effort. The resultant lack of cooperation renders Petitioner's testimony regarding the number of job offers she received unreliable. As such, the scant number of job offers Petitioner received is a direct result of Petitioner's failure to comply with her vocational counselor's instructions.

The Commission further agrees with the Arbitrator's assessment that the Petitioner's efforts in her job search essentially involved going through the motions and doing as little as she had to do, based on Weber's testimony and detailed vocational rehabilitation report. The Commission therefore finds that Petitioner has not sustained her burden of proving by a preponderance of the evidence she is permanently and totally disabled under Section 8(f) or that she falls under the "odd-lot" category because she has not shown a diligent attempt to find work.

Moreover, Petitioner has not established that because of her age, skills, training and work history she will not be regularly employed in a well-known branch of the labor market. Petitioner was 46 years old at the time of the accident and there is no evidence her age has any bearing on her employability. Hew work experience is varied and indicative of an individual capable of finding employment. She is a high school graduate and member of the operator's union. Therefore, the Commission agrees with the Arbitrator's finding that Petitioner failed to prove she is permanently and totally disabled as a result of the 10/27/11 accident.

The Commission differs from the Arbitrator's Conclusions of Law with respect to Petitioner's entitlement to an award under Section 8(d)1 of the Act. A review of the pertinent sections of Sections 8(d)1 and 8(d)2 and relevant case law establish the word "shall" in Section 8(d) (1) dictates that where a claimant proves that he is entitled to a wage-differential award, the

Commission is without discretion to award a Section 8(d) (2) award in its stead. The only exception to this rule is where the claimant waives his right to recover under Section 8(d) (1). See 820 ILCS 305/8(d) (2) (West 1992). See *Freeman United*, 283 Ill. App. 3d at 791 (explaining that where the claimant could fit under either Section 8(d) (1) or 8(d) (2), employee receives a wage-differential award unless he waives such right and opts for a percentage-of-the-person-as-a-whole award). *Gallianetti v. Industrial Comm'n (Asplundh Tree Expert Co.)*, 315 Ill. App. 3d 721, 729, 734 N.E.2d 482, 488, 248 Ill. Dec. 554, 560.

In order to qualify for a wage differential award under Section 8(d)1 of the Act, a claimant must prove (1) a partial incapacity that prevents him from pursuing his "usual and customary line of employment" and (2) and an impairment of earnings. 820 ILCS 305/8(d)(1) (West 1998); *Gallianetti v. Ill. Workers' Comp. Comm'n*, *Gallianetti v. Industrial Comm'n (Asplundh Tree Expert Co.)*, 315 Ill. App. 3d 721, 734 N.E.2d 482, 248 Ill. Dec. 554.

The Commission is not convinced that the subject Petitioner's partial incapacity that prevents her from pursuing her usual and customary line of employment is related to the subject work accident as it appears that Petitioner had an intervening accident. The first MRI on October 27, 2011 noted no definite disc protrusions or disc herniations identified. Four months after the accident, by February 28, 2012 the Heartland Regional Medical Center records reflect Petitioner's pain rating at the beginning of treatment was "2" (on a scale of 1-10) and at the end was "1". She then began work hardening/conditioning. On February 28, 2012, Petitioner also demonstrated normal (100%) spinal AROM regarding flexion, extension and rotation. When she was discharged from physical therapy on March 31, 2012, the therapist documented that Petitioner reported intermittent pain relief as low as 0-1/10 at times but she had no effective lasting pain relief.

In April 2012, Petitioner reported to Dr. Newell a return of pain symptoms once beginning work conditioning. (Px4) He prescribed another round of physical therapy. The Commission notes, however, that on July 15, 2012, the Heartland Regional Medical Center's records document Petitioner's increased anxiety and depression from domestic stressors and moreover, that on the prior Wednesday, "a 16-wheeler backed into her passenger side while she was parked; pushed car back 5 (five) parking spaces" (Px5) No other medical records related to this intervening accident were entered into evidence, however, the Commission notes that Petitioner saw Dr. Newell on July 30, 2012 and Petitioner reported the pain had returned to her back and legs. He put a hold on therapy and recommended an EMG to evaluate radiculopathy. At that time, and in the months that followed, Petitioner reported blood pressure issues prevented her from participating in physical therapy.

Petitioner had a second lumbar spine MRI several months later on December 5, 2012. Dr. Lee compared the two MRIs and opined the disc protrusion at L4-5 had increased 2 mm. The Commission notes, however, Petitioner never reported getting hit by a "16-wheeler" to Dr. Lee. Therefore, the Commission finds Dr. Lee's causation opinion is entitled to little weight. *See, e.g.*, *Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

Despite complaining of bilateral lower extremity radiculopathy, the January 25, 2013 EMG study was a normal study lending little credence to Petitioner's continued radiculopathy

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complaints.

In light of the afore-referenced findings regarding Petitioner's lack of credibility, the Commission also agrees with the Arbitrator regarding the insufficiencies of the September 6, 2013 functional capacity report (FCE) and specifically the reliability of Petitioner's subjective pain report. The therapist noted reliability of pain testing was performed to determine "whether the client's pain reports can be considered as limiting factors during functional testing. The following evidence-based items were tested to determine the reliability of pain and were determined to represent unreliable pain reports. The testing results included poor psychodynamics during the McGill pain questionnaire and the Oswestry low back disability questionnaire." (Px4, 9/6/13 FCE).

The Commission finds the video surveillance is also compelling enough to establish Petitioner is capable of physical activity contrary to the FCE results. The lengthy management of and participation in the landscaping project supports the unreliability of the FCE in the case at bar, and makes it impossible to determine Petitioner's actual physical restrictions or limitations.

Even if, arguendo, the Petitioner proved partial incapacity that prevented her from pursuing her usual and customary line of employment, the Commission finds the Petitioner does not meet her burden of proving an impairment of earnings. Petitioner clearly has transferable skills however, her lack of vocational rehabilitation effort sabotaged retraining efforts. Petitioner tendered little to no documentary evidence of her job search efforts except what was spoon fed by the vocational counselor, Ms. Weber. Therefore, application of Ms. Weber's labor market survey (LMS) is flawed.

Even if the February 17, 2015 LMS provided by Ms. Weber was considered reliable, the LMS results showed Petitioner was capable of earning up to $15.83 per hour even when premised on the unreliable FCE result. Ms. Weber's flawed LMS still establishes the median annual salary for positions for which Petitioner is qualified were between $27,000 and $37,000.00 according to Salary.com on February 17, 2015. The highest of the median salaries is less than $2,000.00 different than Petitioner's annual AWW salary. Therefore, the Commission finds the Petitioner would have the potential to reach the AWW rate she was earning at the time of the subject accident which was approximately $38.00 per week more than the highest median annual salary listed in the LMS for the documented job titles.

Therefore, the Commission finds that Petitioner failed to prove she is entitled to a wage-differential award under Section 8(d)1, relying on the Petitioner's testimony, the medical and vocational rehabilitation evidence and the record as whole which established Petitioner failed to engage in a good faith vocational rehabilitation effort with Respondent's vocational counselor, that Petitioner's job search efforts were minimal, and that she demonstrated little intention of going back to work.

The evidence in the record, therefore, does not support a finding that the claimant was entitled to a wage differential award *i.e.* that she suffered a partial incapacity which prevents her from pursuing her usual and customary line of employment that led to an impairment in earnings. The Commission, in considering a wage-differential award under Section 8(d)1, finds Petitioner

failed to prove entitlement to same. Instead, the Commission awards permanent partial disability (PPD) benefits under Section 8(d)2. Accordingly, the Commission vacates the Arbitrator's 8(d)1 award of 233.23 per week and finds that Petitioner sustained PPD to the extent of 40% loss of use of the person as a whole under §8(d)2 of the Act.

With regard to the issue of temporary total disability (TTD) benefits, the Commission finds the Petitioner is entitled to TTD benefits of $499.90 per week for 97 weeks from October 28, 2011 through September 6, 2013, that being the period of temporary total incapacity for work under Section 8(b) of the Act. In so finding, the Commission relies upon the parties' stipulation contained within the request for hearing (Arbx1) which reflects Petitioner was entitled to TTD through September 6, 2013 which coincides with the date the Petitioner completed the FCE.

With regard to the issue of maintenance benefits, the Commission finds Petitioner's entitlement to same terminates as of September 9, 2016, the date of the arbitration hearing, as the overwhelming evidence indicates that Petitioner refused to comply with the vocational assistance offered to her. Although the Commission agrees with the Arbitrator that the Petitioner's vocational services had been maximized by January 1, 2016, the Respondent stipulated to the period of entitlement from September 7, 2013 through September 9, 2016. Therefore, the Commission modifies the Arbitrator's Conclusions of Law, with respect to Issue (K), the amount of compensation due for TTD, temporary partial disability and/or maintenance by striking the first and last sentences in the second paragraph under (K) and substituting the following for the last sentence: The Commission finds that Petitioner is entitled to maintenance benefits of $499.90 per week for 157 weeks, from September 7, 2013 through September 9, 2016. In so finding, the Commission relies upon the parties' stipulation contained within the request for hearing (Arbx1) which reflects Petitioner was entitled to maintenance from September 7, 2013 through September 9, 2016.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed June 2, 2017 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 $499.90 per week for a period of 97 weeks, from October 28, 2011 through September 6, 2013, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $499.90 per week for a period of 157 weeks, from September 7, 2013 through September 9, 2016, that being the period of maintenance entitlement under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's finding that Petitioner is entitled to a wage differential award of $233.23 per week under §8(d)1 of the Act is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $449.91 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 40% loss of use of the person as a whole.

18IWCC0423

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 6 - 2018
KWL/bsd
O: 5/14/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BURDETT, LADREAMA
Employee/Petitioner

Case# **13WC011012**

SOUTHERN ILLINOIS UNIVERSITY-CARBONDALE
Employer/Respondent

18IWCC0423

On 6/2/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4128 RUBENS AND KRESS
FRANK D KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0558 ASSISTANT ATTORNEY GENERAL
SHANNON D RIECKENBERG
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

JUN 2 - 2017

RONALD A. RIOPELLE, 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

LADREAMA BURDETTE
Employee/Petitioner

v.

SOUTHERN ILLINOIS UNIVERSITY - CARBONDALE
Employer/Respondent

Case # **13** WC **11012**

Consolidated cases: _____

18IWCC0423

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **September 9, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 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 **$3,749.27**; the average weekly wage was **$749.85**.

On the date of accident, Petitioner was **46** years of age, *single* with **1** dependent child.

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

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

Respondent shall be given a credit of **$N/A** for TTD, **$N/A** for TPD, **$77,201.99** for maintenance, and **$N/A** for other benefits, for a total credit of **$77,201.99**.

ORDER

Respondent shall pay Petitioner maintenance benefits of **$499.90** per week for **157 weeks**, commencing **September 7, 2013 through September 9, 2016**, as provided in Section 8(a) of the Act.

Respondent shall be given credit for **$77,201.99** for maintenance benefits paid under Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, **commencing September 10, 2016**, of **$233.23 per week** for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act. Because this accident occurred subsequent to September 1, 2011, this award shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later.

Respondent shall pay Petitioner compensation that has accrued from **September 7, 2013** through **September 9, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

18IWCC0423

Signature of Arbitrator

May 31, 2017
Date

JUN 2 - 2017

STATEMENT OF FACTS

The Petitioner, a Marion, IL resident, testified that she was an operating engineer, with a CDL license, and was employed on 10/27/11 by the Respondent as a Maintenance Equipment Operator. The job involved driving a truck and loading and unloading supplies and materials. On Tuesday/Thursdays she would supply the campus with cleaning and bathroom supplies, and on Monday/Wednesday/Fridays she worked in "receiving". This involved loading and hauling away items to the receiving area or to other designated locations. This could include refrigerators, couches, air conditioners, tables, etc. They would be moved by hand, including use of carts and dollies, and involved lots of pulling, lifting and tugging. She could be lifting upwards of 100 pound items.

On 10/27/11, she was working out of Lentz Hall clearing out a cafeteria area, including refrigerators and other large items. She bent down to pick it up a heavy panini grill, felt it was too heavy, had to let it go, and it "tore out my back". She testified she developed rapidly worsening burning and stinging like she tore a muscle. She was taken by ambulance to the Carbondale Memorial Hospital emergency room. She reported lifting a heavy grill and feeling a "tear" in her low back with severe low back pain. The ambulance report noted complaints of pain down her legs. Lumbosacral x-rays showed no acute injury and facet arthropathy at L4 to S1. A lumbar MRI reflected degenerative disc disease from L3 to L5 with superimposed facet joint arthropathy, most severe at L3/4 resulting in mild to moderate central canal stenosis. There was mild L4/5 facet arthropathy with mild foraminal stenosis, and no evidence of disc herniation. She was diagnosed with a back strain, taken off work and advised to follow-up with her primary provider. (Px4).

Petitioner saw nurse practitioner (N.P.) Gina Gunther at Johnston Community Health Center on 10/31/11. The work injury was noted, and Petitioner reported back pain radiating to the gluteal area and right thigh for five days with no prior low back problems. Lumbago was diagnosed, she was held off work and pain medication was prescribed. She returned on 11/7/11, was released to light duty and physical therapy was recommended, which she began at Heartland Regional Medical Center on 11/28/11. (Px3 & Px5).

On 12/5/11, N.P. Gunther noted that the Petitioner's problems were fluctuating persistently. Petitioner complained of radiating pain into the bilateral thighs with burning, sharp and shooting pain. She was restricted to sedentary work duties. On 1/10/12, she reported an exacerbation of pain when she twisted her body to get on an elevator. By 3/2/12, after several weeks of physical therapy and work conditioning, the Petitioner returned to Johnston Community Health Center complaining of increased pain into her legs with work conditioning, and was referred to Dr. Newell at the Rehabilitation Institute of Chicago at Southern Illinois Healthcare (RIC/SIH). (Px3).

Petitioner initially saw Dr. Newell on 4/25/12. She provided a consistent history of the accident and reported some improvement with medication and therapy until her symptoms worsened with work hardening. Following his review of the lumbar MRI (noting it reflected mild to moderate facet arthropathy from L3 to L5, L3/4 bulge, mild/moderate central stenosis at L3/4 and mild/moderate foraminal stenosis bilaterally at L4/5), Dr. Newell diagnosed a lumbar disk bulge at L3/4 with lumbosacral radiclulitis and prescribed a lumbar epidural, both for therapeutic and diagnostic purposes, and held Petitioner off work. Following the initial 5/14/12 epidural injection, Petitioner returned on 5/30/12 and reported good relief with regard to radiating symptoms, but that she continued to have back pain. (Px2). Therapy was prescribed, which was performed at Joyner Physical Therapy (Px4). She returned to Dr. Newell on 6/27/12, who noted she had been in therapy for only a week and: "it sounds like there was some miscommunication on getting that set up. She remains off work because she claims there is no light duty available." Physical therapy was continued, and she was kept off work. (Px2).

On 7/7/12, Petitioner was discharged from Heartland Regional Medical Center following a 7/2/12 admission for a variety of ailments, including low back pain. Petitioner was given an IV of morphine while admitted and advised to take vitamin D and eat lots of green, leafy vegetables upon discharge. (Px5). Some of the medical records in evidence reflect allegations by the Petitioner that she developed both hypertension and headaches as a result of the 5/14/12 epidural, but the Arbitrator notes that the preponderance of the medical evidence does not support a causal relationship of these conditions to the epidural.

On 7/30/12, after only two sessions of therapy, Dr. Newell noted that blood pressure issues were interfering with the Petitioner's ability to participate. She reported the pain had returned in her back and legs. He put a hold on therapy and recommended an EMG to evaluate radiculopathy. (Px2).

On 8/15/12, the Petitioner was seen at Trinity Neuroscience Institute for an initial evaluation. It was noted that the Petitioner was suffering from headaches and low back pain. The notes indicate that the Petitioner's headaches began within ten minutes of her initial 5/14/12 epidural steroid injection. Pain medication was recommended and Petitioner was to follow up in a month. (Px1).

On 8/20/12, the Petitioner reported blood pressure issues continued to prevent her from participating in therapy, and she noted mainly back pain that intermittently involved her legs. Dr. Newell noted she had undergone an examination and Petitioner reported that surgery was discussed. He prescribed therapy while she continued to work on her blood pressure, as well as sedentary work restrictions. On 9/18/12, Dr. Newell noted Petitioner was to start therapy, and that a separate examiner recommended another epidural, which Newell was hesitant about given the blood pressure issues after the initial one. On 10/9/12, Dr. Newell noted that the Petitioner had been able to resume physical therapy and that another injection might be considered after completion, depending upon the symptoms at that time. On 11/6/12, due to a lack of progress, Dr. Newell recommended another epidural steroid injection to get Petitioner to try to get her to where she could participate in work conditioning, noting he questioned the relationship of the prior epidural to Petitioner's hypertension, and a new MRI. Neurontin was prescribed and sedentary duty continued. (Px2).

The 12/5/12 repeat MRI noted normal alignment, no acute compression fracture, and a small focal area of bone marrow edema at the left L5 pedicle, which could be stress response/reaction. Changes of discogenic and degenerative joint disease in the lumbar spine were noted, most marked at L3 to L5 with disc desiccation. At L3/4 there was a disc bulge with moderate to marked facet arthropathy and ligament flavum hypertrophy, which caused central canal and bilateral foraminal stenosis, marked on the left and moderate on the right. At L4/5 there was a disc bulge, marked facet arthropathy and prominent epidural fat, resulting in central canal stenosis, and marked left and moderate right foraminal stenosis. (Px2). On 12/10/12, Dr. Newell reviewed the new MRI and

commented that it showed significant degenerative changes, facet joint arthropathy and disk bulges at L3/4 and L4/5. He recommended a neurosurgical consultation. (Px2).

On 1/14/13, the Petitioner was again seen at Trinity for follow up. After the MRI was evaluated, it was recommended that Petitioner undergo NCV testing to assess her complaints of pain into her thighs. (Px1). The EMG/NCV was performed on 1/25/13, and was noted to be normal, with respect to both radiculopathy and/or peripheral neuropathy. (Px2). On 2/4/13, Petitioner presented to Dr. Fleming with the Center for Medical Arts to address her lumbar disc displacement and radiculitis. Dr. Fleming recommended surgery, which the Petitioner stated she wished to avoid while also indicating that she could not live with her pain. Lumbar epidural injections were recommended as an alternative. (Px1).

At a 2/11/13 follow up with Dr. Newell, Petitioner reported having been in a "flare-up" when she saw Dr. Jones. He concurred with Jones and prescribed a repeat L4/5 epidural, and this was performed on 2/28/13. (Px2). On 3/8/13, the Petitioner returned to Trinity for follow up. She reported some relief from the most recent injection, and Dr. Criste opined that it was unlikely that her headaches were due to the injections. He believed that Dr. Newell's treatment was appropriate, and it was recommended that Petitioner return to Trinity as needed. (Px1).

On 4/3/13, Petitioner returned to Dr. Newell, reporting almost 30% improvement with the 2/28 epidural, but it was wearing off, and that she felt she was making progress in therapy until Respondent stopped approving it after 5 visits. (Px2). The notes of Joyner Physical Therapy confirm that Petitioner was discharged on 4/9/13 due to a lack of payment by workers' compensation (Px4). On 4/16/13, a Utilization Review was obtained by Respondent which denied 12 additional sessions of PT, as recommended by Dr. Newell, as being not medically necessary given the Petitioner already having had a reasonable amount of PT with limited progress, and the low likelihood of significant additional benefits. (Px4).

Another epidural was performed on 4/25/13. Following the injection, the Petitioner returned to see Dr. Newell on 5/15/13, indicating 1 to 2 weeks of really good relief, and he recommended a final injection in conjunction with a regimen of work conditioning. On 6/14/13, Dr. Newell noted the final epidural wasn't performed because Petitioner had issues with chest pain and was in the midst of being worked up for that. She reported a pain episode bending and reaching into a cabinet that "brought her to the floor". On 7/12/13, Dr. Newell noted that the Petitioner was reporting increased pain that was radiating into the thighs, noting she hadn't had any PT due to blood pressure issues. Petitioner had been cleared from a cardiac standpoint. (Px2). The final epidural was performed on 8/1/13, and the Petitioner began work conditioning at Joyner PT on 8/12/13. (Px4). On 8/15/13, Petitioner reported that, while the injection helped to some degree, her symptoms flared up in work conditioning, to the point that she claimed she was bed-ridden. Dr. Newell indicated that if she was unable to progress with work conditioning, an FCE would be in order. On 9/6/13, Petitioner underwent the FCE at Joyner, and the report stated that Petitioner put forth a "full and consistent effort" and that she exhibited the ability to "bilateral shoulder lift" three pounds. The FCE stated Petitioner demonstrated the ability to perform approximately thirty-five percent of the physical demands of her job as an operator engineer, an occupation requiring a heavy physical demand level, and that the Petitioner put forth a consistent effort approximately eighty-six percent of the time. However, the FCE also indicates that pain was a limiting factor during the testing, and that while some of the testing indicated her pain complaints were reliable, it was also noted that there were some inconsistencies, and that Petitioner had poor psychodynamics which resulted in the potential for unreliable pain reporting. The Arbitrator found this FCE to be difficult to use to ascertain specific restrictions. The idea that the Petitioner was unable to tolerate any weight whatsoever with regard to lifting, carrying, pushing and pulling does not make sense to the Arbitrator.

At Petitioner's last visit with Dr. Newell on 9/20/13. he prescribed work restrictions based on the FCE results. without further specificity. and indicated Petitioner would be at MMI at her next visit. As noted, the evidence does not indicate another visit to Dr. Newell after 9/20/13. (Px2).

On 2/27/14, the Petitioner was examined by Dr. Thomas Lee of Tesson Heights Orthopedics pursuant to Section 12 at the Respondent's request. Dr. Lee reviewed the 10/27/11 and 12/5/12 MRIs, which he stated reflected an L4/5 herniation and L3/4 disc protrusion at L3/4, and that the L4/5 disc had increased in size. He also noted that extension/flexion films showed a translation of 4.5 mm of anterolisthesis in flexion at L3/4. Dr. Lee stated that Petitioner had shown a progression of weakness and had clinical signs of radiculopathy. He recommended lumbar fusion at L3/4 and L4/5 and recommended current restrictions of lifting no more than 10 to 15 pounds, frequent changes in position, and avoidance of bending at the waist. He noted that the restrictions would decrease after completion of the surgery and healing process. Dr. Lee found the restrictions and need for surgery to be related to Petitioner's injury sustained at work, essentially under a chain of events analysis. (Px7). The Arbitrator believes that the restrictions indicated by Dr. Lee involve a greater degree of credibility and specificity than that of the FCE and Dr. Newell.

It appears that the Petitioner has chosen not to undergo surgery. After EMG, Petitioner testified that Dr. Newell and the MDs at Trinity both believed she was not a surgical candidate. It was explained to her that she had a degenerative disc and stenosis. Newell explained that a procedure could give 10% relief, but that she would ultimately be in the same boat a few years later, and that there was no cure for the degenerative process. As of the date of the hearing in this matter, the Petitioner testified that she remains unemployed. She received a letter from Respondent dated 12/23/12 indicating she was terminated, and believed it stated this was due to non-participation, because she wasn't at work and treating. There was testimony that Petitioner was in an apprenticeship via the union hall, and they were aware of the termination. Jenny Batson, Respondent's workers comp coordinator since 2007, testified on behalf of Respondent. She testified that Petitioner's position as a maintenance equipment operator was terminated due to failure to progress in the apprenticeship program, the determination of which is made by the joint training committee. She was notified of this via a letter from Phil Gatton, Respondent's Director of Plant & Service Operations. The decision is made by the Joint Training Committee.

The Petitioner was evaluated at her attorney's recommendation on 8/24/14 by Alide Shemshedini of Vocamotive to determine if a stable labor market existed for her within her permanent medical restrictions. The 8/24/14,authored a report that concluded that no stable labor market existed for the Petitioner in the greater Marion area given the Petitioner's age, education, lack of computer skills, work experience, and physical limitations (Px6). The Respondent submitted the Petitioner for vocational rehabilitation services with Helen Weber of Creative Case Management on 12/22/14, and she commenced an effort to assist the Petitioner with obtaining alternative employment. Her reports are compiled as Respondent's Exhibits 9 through 15, which includes a labor market survey. The Arbitrator notes that he reviewed these reports in detail.

Petitioner testified she initially met with Helen Weber on 12/23/14 at Marion's Carnegie Library and went over her work history and their roles in the process. Weber would provide job leads for Petitioner to apply for. Petitioner did not have a computer so she would use her iPhone instead, which she testified was time consuming. Weber showed her how to look through online job boards. Petitioner essentially testified that she had difficulty using a computer to complete the tasks, and her use of the iPhone resulted in times where Weber couldn't track and confirm whether she completed applications or not, and because she couldn't always spend a lot of time with Petitioner, "a lot of things kind of slid through the cracks".

Petitioner testified she is a 1983 high school graduate, had a child and was a stay at home mom until returning to school taking general studies in 1987, but she then had more children. She testified she was not a good student. She had experience as a Casey's and WalMart cashier, but testified she had no experience working with a personal computer. It appears that the Petitioner worked for the Respondent for 5 weeks prior to the accident. Prior to this, she was an operating engineer with E.T. Simonds and Illinois Asphalt for 3 years in seasonal employment. She would work 5-6 months per year and be laid off the remainder of the year. Initially, the vocational job leads were mainly desk work with no real physical work. At some point she told Ms. Weber she didn't understand why Respondent wouldn't pay to send her back to school, and at some point this was approved.

Petitioner testified that when she began taking classes at John A. Logan College she was not provided with any books. Petitioner stated this was due to Ms. Weber not being able to get her a book voucher, and thus this was not her own fault. Petitioner testified the class required her to do work online, and again indicated she had never owned a computer before this. She discussed this with Ms. Weber and they agreed that Petitioner should withdraw and start the class over. Petitioner testified she would call Ms. Weber often for help, and that Weber would always help her, but testified: "and it would not stick really." Before she started the class again, Petitioner bought a computer, but she agreed Weber told her she could use a computer at the library. After the Petitioner re-started the class, she testified the instructor indicated the class was over her head, and that this was very demeaning and embarrassing for her. Petitioner claimed she and Ms. Weber agreed that she would remain in the class to gain as much knowledge as possible so it would be easier the next time, and Petitioner said she continued until it became overwhelming. Ms. Weber then found some type of online typing class for Petitioner via Shawnee Community College. Petitioner started the 5 week computer class, which she said was for senior citizens, 2 weeks late. She indicated difficulty with cutting and pasting despite Weber's help. Petitioner stated that when she was enrolled in a class, Weber would limit her job search requirements to help her succeed. She completed the Shawnee class in May 2017.

While in school Petitioner testified she continued to look for work online, and while she would try to get out and walk once in a while, she wasn't always looking in person. Sometimes she would ask for applications in person and would be told she had to apply online. Petitioner testified she would always make her 30 job contacts biweekly, but discrepancies would occur when Weber couldn't confirm the applications, both with the iPhone and then later the computer. Sometimes Weber would find them. Petitioner could recall getting only three job interviews, two of which were sales for Kirby vacuums, and the interviewers thought she wasn't physically going to be able to carry the machine and clean carpets. The third was for a Little Caesars management job, but she testified it required computer literacy, so she didn't get a call back. She asked them about other positions, and was told even store managers have to lift. Petitioner has accounts with Indeed.com and Monster.com and can apply for jobs online, using her phone or computer.

On cross exam, Petitioner testified that general activity increases her pain on a daily basis, and she has to rest until it improves, though the pain never completely resolves. Petitioner wasn't certain if she'd undergone any related medical treatment since the Dr. Newell's release, noting she no longer had a medical card and didn't want to spend money out of pocket given both Gunther and Dr. Newell had indicated there was nothing more they could do for her other than medication, which she testified doesn't help. Yet, she testified she continued to take Neurontin, Tylenol (OTC) and Topirmate, and would get prescriptions from Gunther's replacement, Jessica Mathena, who "knows" she is hurting. She takes Tylenol daily.

Petitioner lives with her oldest son (16 y/o), and occasionally the boy's father. She does some housework, but has to take breaks. Sometimes the child's father feels guilty and performs some housework. Petitioner indicated her son and his father, as well as her nephew and his girlfriend, will perform outdoor yard work. Petitioner

testified she owns a 2015 Mustang in her name, which the child's father put a $3,000 down payment on and who splits the payments with her. She denied filing for social security disability.

Petitioner has owned a smart phone for 5 years and has had no problems using it outside of the job search. Before she bought a computer, the Petitioner agreed Ms. Weber indicated Petitioner could use the library computer, which was about 10 minutes away. She never asked if John A. Logan had computers she could use. She agreed Weber walked her through how to use online job search apps multiple times and would address any questions she had. Weber would sign her up for her classes. As to the resume Ms. Weber requested, Petitioner testified she didn't have a computer the first, week, said she would have her sister help her, and then her sister went out of town, so she didn't get it done until the sister came back. Petitioner questioned why the resume wasn't completed for her by Weber.

Weber explained to her that she would need Petitioner's email password to verify her activity, and her vocational email account was connected to her iPhone, so Petitioner wasn't sure why Weber couldn't find some of her confirmations. Petitioner claimed that some of the ones Weber said she couldn't find were then found on Petitioner's phone. She would meet with Weber at various times, between weekly and monthly, and she would always receive tasks. Petitioner estimated that she met her job search task requirements 98% of the time. She might have fallen short on a few, but would make a point of doing more applications at those times to meet the requirements. If Weber's reports indicated only 7 out of 43 were complied with, Petitioner would be surprised. She performed about 3 or 4 search tasks on her phone before Weber asked her to use a real computer. Petitioner would sometimes perform job search tasks daily, and sometimes she would have days where she wouldn't do anything. The sheet didn't indicate she had to make the contacts daily, just that they had to be completed within a time frame.

Petitioner believed she had undergone training and/or certification for CPR, OSHA, forklift use and Hazmat. She also agreed she had some vocational operators training through her union during the winter months when she had the seasonal job. She testified she had training and was able to operate a roller in the field, though she wasn't good at it and had difficulty running other machines.

Petitioner testified that she told Ms. Weber she always wanted to be a paralegal, but that "they" indicated that training as a medical assistant would be better because there were more jobs available. She applied for a wide variety of jobs. As to how she would follow up on her applications, Petitioner testified: "Some of them I would just call back and just try to find out and then a lot of them when you're going back through the next week you're seeing that the jobs have already been expired and stuff." Asked if it was the case that she wouldn't necessarily follow up on those jobs, Petitioner testified: "I didn't know I had to follow up on jobs like that. . . . I just thought that we were to apply for jobs." She applied to about 15 jobs in person, and testified that she would spend an average of 2 to 3 hours per week on the job search.

Certified vocational rehabilitation counselor Helen Weber (Creative Case Management - CCM) testified that she has worked for CCM for 2 years out of Newton Illinois, and has been a vocational counselor since 2001. She testified that she evaluated Petitioner, prepared an LMS and had approximately 45 in person meetings with Petitioner as part of the vocational process. Petitioner's demeanor was cooperative and friendly throughout her services. Weber reviewed Petitioner's medical records and job description, and she understood Petitioner's restrictions. Based on the educational history she was provided by Petitioner, there was no indication she had any type of learning difficulties or disability. She had experience in various job positions. There was no specific profession that she had overwhelming experience in, but had experience in various job positions, each for about the same length of time.

Petitioner indicated she was essentially a material mover for Respondent and didn't operate heavy equipment. Weber opined Petitioner's age, as an older worker, could work against her, but that age does not necessarily impact how she goes about finding employment opportunities. Petitioner had worked as a cashier, photography assistant and heavy equipment operator in the construction industry, and had familiarity with working with people. She felt Petitioner had an engaging personality that would allow her to interact well with people. Ms. Weber testified that she believed Petitioner is employable within her restrictions. She testified she is familiar with the Marion market as most of her clients are in Southern Illinois, and noted that in that region Marion has one of the stronger labor markets. She did testify on cross examination that, with her current skill set, Petitioner's employability was likely limited to jobs at the $8.25 per hour minimum wage or slightly above that.

Ms. Weber testified that Petitioner had difficulty completing her vocational assignments. She believed Petitioner understood those assignments, as they would review them together. Petitioner did have difficulty with computers, but Weber testified they repeatedly went over how to utilize a computer for the job search process. She would send emails with hyperlinks to job applications, and also went over how to get to the necessary site if the link didn't work. They went over how to complete online apps, how to confirm they were submitted, and how to upload a resume. With regard to the resume, Weber testified that Petitioner was asked to provide a rough draft, that it took a couple of requests for her to provide this, and that Weber then helped to revise it. Petitioner did indicate difficulty with the task. Ms. Weber testified that there were times Petitioner had health issues and losses of family members, during which time Weber didn't require any job contacts. Overall, in terms of completed job applications, Weber testified that Petitioner did not have good compliance. As to effort, Weber opined that steps could have been taken by Petitioner to increase her chances of finding employment. At times she felt Petitioner was giving a good faith effort, and at other times she felt Petitioner could have given greater effort. She agreed that it appeared that Petitioner was going through the motions "to some degree" with regard to seeking employment.

Weber had access to Petitioner's vocational email account and would have seen any application confirmation emails. When Petitioner was using her iPhone, she could not locate any kind of confirmation of a completed application. She would also look at her online profiles on job search websites and was also unable to find confirmation there. For applications the Petitioner made by phone, Weber would call the prospective employer to verify. Weber tried every avenue she could to find the confirmations. She agreed Petitioner would sometimes show her screenshots on her phone, but this wasn't reliable because it would involve partial screen shots or wouldn't indicate the job that was being applied for. She testified: "I know at times I took her word for it but eventually we just got to the point where I said we really need to be able to have something in an email for confirmation." Weber testified she hasn't had these issues with other clients, including clients of Petitioner's education level and who had minimal computer experience. At times, when Weber would check Petitioner's email, there would be requests from prospective employers that needed to be responded to, and Petitioner's failure to respond quickly may have hindered her search. This would be discussed when at their meetings. She acknowledged that Petitioner would sometimes request assistance to respond, and Weber would help her.

At their initial meeting Weber and Petitioner discussed various training programs that could help her secure employment, and Petitioner said she preferred local John A Logan College. Weber was looking for mainly clerical-type positions that were more sedentary, and they discussed legal, administrative and medical assistant. Petitioner preferred to work towards legal assistant, while Weber preferred administrative assistant to increase her labor market, but the initial courses were similar either way. Ms. Weber testified that Petitioner was asked to register didn't get her materials in on time. She testified: "Ms. Burdett contacted me via phone and reported that she was behind in her classes and she had thought about not continuing to attend those. I advised her to speak to her legal counsel and to go ahead and go to the class, I believe it was the first day of class. I believe she did attend the first day of class and then we had a vocational meeting shortly after that and then knowing that she

was already a week behind on those classes I think we agreed together that it would be better for her just to wait until the next semester instead of being behind and trying to catch up." Weber conceded that when Petitioner reported she couldn't get her books, the college bursar's office indicated she was in the system but they couldn't bring up Petitioner registration and couldn't find her books.

The Petitioner took an online keyboarding class the next semester (summer 2015), which required Petitioner to submit everything online via a specific program from Logan College. She also signed up for intro to computers – Weber testified Petitioner was not successful in the class but gave good effort, even signing up for a tutor. Her instructor at John Logan recommended that she needed more basic instruction. Noting she believed it was shortly before classes were to begin, when Petitioner went to register for classroom-based keyboarding, the class was already full. Petitioner started a free basic noncredit course at Shawnee Community College after the class had already begun, and Weber agreed she indicated this was a good start and that she should learn as much as she could in a classroom setting.

With regard to the vocational reports prepared by Vocamotive in 2014 and 2016, Ms. Weber testified that the report heavily leaned towards hotel desk clerk jobs, and that her opinion was that there is a stable labor market for Petitioner in the Marion area. She disagreed with their conclusions that the leads she provided to Petitioner were not appropriate. She did not consider jobs that required skills beyond what Petitioner had, but agreed she would consider prospective jobs where a skill Petitioner didn't have was only preferred, and noted that reasonable accommodations could be made by prospective employers in jobs at the light work level. In Ms. Weber's opinion, the Petitioner could have increased her chances of securing employment if she had better follow up with her applications.

As to the Petitioner's chances of employment, on cross exam Ms. Weber testified this was "guarded", meaning "she had some significant barriers, but I still felt like there might be something out there for her." She also testified: "I feel like with additional skills, maybe some job training she would be more likely to secure employment." Ms. Weber agreed that Petitioner's physical restrictions limited her to sedentary duty, and that only 20% of all jobs would be considered sedentary. She also conceded that among sedentary jobs, a lack of computer skills limits that labor market even further. Petitioner's age also reduces her employability chances versus a younger worker. She agreed that Petitioner's computer instructor from Logan College, Diane Rudolph, expressed concern with Petitioner completing the class due to a lack of skills. That's why they took a step down in classes. Asked if she thought there was a volitional aspect to Petitioner not doing well with computers, Ms. Weber testified: "I don't feel like she misrepresented herself in her computer skills but honestly I would question sometimes just her lack of being up on the information when presented to her." Weber agreed that some skills are just difficult to learn.

On redirect, Weber testified Petitioner didn't have zero computer skills, noting she could operate her iPhone and had run a cash register. She believed Petitioner might have been more successful if she hadn't essentially procrastinated with regard to her classes, and that a reasonable person could have done it without instruction. Again, while Petitioner was completing some applications, most of the time she didn't complete the required number of contacts.

Certified vocational rehabilitation counselor Keri Stafseth (Vocamotive) testified on behalf of the Petitioner. She testified that a telephone interview of Petitioner was performed, along with a review of pertinent medical records, and an initial evaluation and labor market survey (LMS) were prepared in July or August of 2014. The LMS was prepared based on a geographical range of 30-50 miles from Petitioner's residence. Based on the LMS, Petitioner either couldn't meet the job demands academically or the physical requirements of the prospective employers, 23 of which were contacted in the Marion, IL area.

Based on the evaluation, there is no viable and stable labor market for the Petitioner in the Marion area. Stafseth testified that a determination of no stable labor market is not a common finding in an LMS. Given Petitioner's location, restrictions and employment history, she did not feel Petitioner had the administrative skills required for most of the jobs that would fit within her work restrictions. She testified: "After contacting (23) prospective employers for positions that we felt would be most suitable to Ms. Burdett (in the Marion geographical area) it was found that employers either weren't able to provide appropriate accommodations for her restrictions or she did not meet the qualifications of those jobs as far as academically speaking."

Ms. Stafseth testified that she reviewed the reports of CCM's Weber, including their LMS, which reflected 12 positions they felt would be appropriate for Petitioner. However, Ms. Stafseth testified: "My review of numerous contacts that she had made showed that she didn't have the required level of experience or the necessary computer skills to perform those positions." As such, she opined that Ms. Weber's LMS was not indicative of an accurate labor market for Petitioner. Ms. Stafseth noted Ms. Weber's reports showed that Petitioner needed a lot of assistance with job applications due to her computer inexperience. She noted "numerous" job leads that Petitioner had been provided either required some type of certification or education that would be beyond Petitioner's highest level of completed education. This would include positions such as dental assistant, medical assistant and pharmacy technician, which in Stafseth's experience require some type of certification or associate level degree. There were also positions that generally would exceed her physical restrictions.

With regard to Ms. Weber's vocational assistance, Ms. Stafseth testified: "I don't think that (Petitioner) was properly equipped with the tools that she would need in order to have any chance of returning to some type of job." She noted that Vocamotive has an in house computer training center, and Stafseth would have made sure Petitioner was keeping up and helped to resolve any problems she might have. The CCM reports note she didn't complete computer training, and Stafseth testified she wouldn't seek a job for Petitioner which required computer skills that she did not have. Her opinion is that there remains no stable labor market for Petitioner as of the hearing date. While numerous CCM reports indicate Petitioner was non-compliant, she would not consider Petitioner non-compliant if she was supposed to be looking for jobs she wasn't fit to perform.

On cross examination, Ms. Stafseth agreed that most of her experience is working in the Chicagoland and Central Illinois areas, as opposed to Southern Illinois. While she agreed that the Southern Illinois labor market is vastly different than Northern and Central Illinois, the Petitioner would still be facing many of the same barriers either way. Ms. Stafseth couldn't say for sure whether being officed locally could have at least increased the job availability data, but she didn't believe it would have: "because just looking at her profile as far as her education, her skills, also taking into account her restrictions it would be my opinion that those positions wouldn't even be available to her even if they existed within the Marion area."

Her information regarding Petitioner's education and employment history all came directly from Petitioner via a phone conference with Stafseth's colleague, Alide Shenshedini, who Stafseth would supervise and who is no longer a Vocamotive employee. Stafseth agreed that there is value to the interview being performed in person. To her knowledge there was one Vocamotive contact with Petitioner. In Stafseth's opinion, there are no appropriate jobs available to Petitioner given her restrictions, skills and background. If she and Vocamotive had been involved in job placement with Petitioner, they would have recommended vocational testing to assess aptitudes, skills and interests, and to determine any deficits in comprehension, reading, writing, etc.

As to the prospective job targets Ms. Stafseth listed in her LMS, she testified that there were four different target positions: customer service representative, office clerk, dispatcher, cashier and similar positions. There are places that were specifically contacted, and the specific job openings noted were based on data from online job postings.

As to her opinion there is no stable labor market for Petitioner while also identifying these target positions, Ms. Stafseth testified: "So the prospective job targets are just for the labor market survey to assess whether there are any viable positions for Ms. Burdette to do, and after reviewing the data that was completed from that labor market survey as well as taking into account other situational factors, it's my opinion that there are no prospective jobs for her." She agreed that 15 of the noted 18 jobs involved hotels, indicating that this was based on her need to alternate positions, and that front desk agents also don't need advanced computer training, just computer knowledge for that job.

Ms. Stafseth testified that Vocamotive does require that clients make weekly job contacts, and generally seeks to confirm applications/contacts by having clients attach email confirmations to their logs, but they also have clients working on premises for 12 hours per week. If they can't confirm, Vocamotive will make phone calls to prospective employers to get confirmation. She hopes clients are being honest and will give them the benefit of the doubt, but verifications may be needed. Asked how she would define "usual and customary job line", Ms. Stafseth testified: "I would say it's what they've been doing for the majority of the time most recently." To Stafseth's knowledge, the Petitioner had not applied for Social Security Disability at the time of the initial contact. She did not believe any criminal history Petitioner had would hinder her from getting an interview based on current law.

Ms. Stafseth opined that, per Ms. Weber's reports, while Petitioner sometimes would wait until the end of the reporting period to make job contacts, it otherwise looked like Petitioner was applying as needed. She did not recall notations in Weber's reports regarding Petitioner's lack of contact follow ups. She agreed that if a counselor recommended Petitioner apply for a job in person, it would be an issue if she failed to do so. She agreed that it is recommended that clients have a separate email for vocational activities and not use a personal email account. As to whether Petitioner's failures in obtaining student financial aid or in applying for jobs on her own outside of her restrictions and geographical area would be a problem, Ms. Stafseth testified that she would need to know if Petitioner understood the necessary forms and/or where the job locations actually were. Asked if three hours per week spent in vocational activity was sufficient, Ms. Stafseth testified that she recommends full time job search efforts, at least 6 hours per day. She would anticipate that a client would be engaged in job search activity every day of a work week. However, this would assume that there is a viable job market for the client. Overall, she testified: "I would say that I have some issues with how the vocational services were provided to Ms. Burdett to begin with. I think there's some issues with regard to the validity of the services that were provided so it's hard for me to answer that. . . I think that if engaged in the vocational rehabilitation process and if one is, like you brought up about not looking for work every day, that that is something that I would address with a client if they weren't doing that. If the client's not meeting all of the requested number of contacts I would address why not, what's causing you not to meet these expectations and once we find out what the reasoning is for that, then we would move forward."

Currently, Petitioner testified she feels restricted, overwhelmed and that she is never going to be the same. Symptoms include constant pain that gets worse with doing normal activities. She can bend, but testified when she does she knows she will pay for it with worse low back pain. She also testified that her nerve is impacted sporadically: "Like I can turn a certain way or sneeze or cough and it runs from the back of my back down the side of my legs and sometimes through the front depending on how bad it is and then this (right) leg will pinch off like sciatica." She now walks slowly, testifying her legs would go numb at times and she would fall, or the nerve would shoot so hard "I would have to come off that leg and I started falling down." She testified she voluntarily obtained a cane, not per doctor's recommendation, to feel safer from falling, though she doesn't use it when she is just around the house. The Petitioner testified that she had no low back injuries prior to 10/27/11, and has suffered no subsequent back injuries.

The Arbitrator reviewed the surveillance video and reports submitted by the Respondent in this case (Rx16, 17 & 18). The Arbitrator does not find the video to be of significant value. The Petitioner initially is depicted walking with a claim and with a relatively antalgic gait. She mainly is either driving for short periods or was watching and instructing other people performing landscaping in her yard. She also sits down often. At the same time, there are medical records in evidence, particularly the report of Dr. Lee close in time to the video being filmed, which note Petitioner having significant difficulty arising from a seated position. That was not the case in the video. There is also evidence in the record of Petitioner complaining of difficulty with bending, and while she only did it a few times in the video, she did so without any observable hesitancy.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Respondent has put the issue of whether the Petitioner's current state of ill-being is causally related to her work accident of 10/27/11 in dispute. The Arbitrator finds that the evidence is clear, based upon the opinions of Dr. Newell and Dr. Lee, Respondent's Section 12 examiner, that the Petitioner's lumbar/low back condition is causally related to the work accident. Both physicians base their opinions on a chain of events analysis. The Arbitrator notes the evidence supports a finding that the Petitioner was working with no apparent low back problems before the accident, and there is no evidence of back problems or treatment prior to the accident. There is no medical opinion in the record that supports an alternative conclusion. Therefore, the Arbitrator finds that the preponderance of the evidence indicates the Petitioner's lumbar spine condition is causally related to her work accident.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE. THE ARBITRATOR FINDS AS FOLLOWS:

With regard to specifically temporary total disability, the Arbitrator notes that the parties have stipulated to the Petitioner's entitlement to TTD from 10/28/11 through 9/6/13, and that Respondent has paid same. The dispute arises with regard to the period of maintenance claimed by Petitioner from 9/7/13 through the 9/9/16 date of hearing. However, the Arbitrator notes that Arbitrator's Exhibit 1 has some level of conflict, in that it appears Respondent has stipulated to this period, but the parties indicate that "termination of maintenance" is at issue. Additionally, the parties have stipulated that the Respondent has paid maintenance benefits totaling $77,201.99.

The Arbitrator finds that the Petitioner is entitled to maintenance from 9/6/13 through 12/31/15. Petitioner began working with Helen Weber in December 2014. The Arbitrator believes that a year was a reasonable period of time for the Petitioner to have participated in vocational rehabilitation with Weber, given other health problems, but that the Petitioner's perfunctory participation. As of 1/1/16, the Arbitrator finds that the Petitioner's vocational services had been maximized, and thus that she was no longer entitled to maintenance benefits as of that date.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner alleges that she is permanently and totally disabled from employment as a result of the stipulated 10/27/11 accident. The Arbitrator finds that the Petitioner has failed to prove entitlement to a permanent total disability award in this case. The evidence does not support a finding of permanent total disability pursuant to Section 8(e), or based on a medical determination that the Petitioner is medically unable to work at all. The Petitioner's allegations are that she is permanently and totally disabled based on an "odd-lot" theory, relying on Section 8(f) of the Act.

Courts in Illinois have described permanent total disability under 8(f) as where a claimant cannot make some contribution to the work force sufficient to justify the payment of wages, and where the claimant is unable perform any services except those for which no reasonably stable market exists. However, where the claimant is qualified for and capable of obtaining gainful employment without seriously endangering health or life, the claimant is not totally and permanently disabled. The Arbitrator and Commission are instructed to consider the employee's age, experience, training and capabilities in making this determination. *E.R. Moore Co. v. Indus. Comm'n*, 71 Ill.2d 353, 376 N.E.2d 206, 17 Ill.Dec. 207 (1978); *Ceco Corp. v. Indus. Comm'n*, 95 Ill.2d 278, 447 N.E.2d 842, 69 Ill.Dec. 407 (1983). The claimant has the burden of proving by a preponderance of the evidence the extent and permanency of his injury. An employee satisfies his burden of proving that he falls into the "odd-lot" category by showing either (1) a diligent but unsuccessful attempt to find work or (2) 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. Once the claimant establishes that he falls into the "odd-lot" category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Westin Hotel v. Workers' Compensation Comm'n*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342, 310 Ill. Dec. 18 (2007). Once the claimant has met this burden, i.e. shows that he or she falls into the "odd-lot" category, then the burden shifts to the Respondent to prove that a job in a competitive market is regularly and continuously available to the Petitioner. When the extent of the disability, along with factors above, indicates the employee cannot perform services except those for which no reasonably stable labor market exists, the Commission may enter an award for total permanent disability even if the employee does not show work was unavailable. *Hutson v. Indus. Comm'n*, 223 Ill. App. 3d 706 (1992). The Appellate Court has noted that the fact that a claimant has submitted evidence of an inability to find a job does not mean the Arbitrator and Commission must find that the burden of proof has been met. *Courier v. Indus. Comm'n*, 281 Ill.App. 3d 1, 668 N.E.2d 28, 217 Ill. Dec. 843 (1996).

Based on a review of the evidence, the Arbitrator finds that the most credible determination of Petitioner's physical restrictions was Dr. Lee's. The FCE, while noted internally to be valid, appears to the Arbitrator to evidence restrictions that are not believable in terms of Petitioner being unable to lift/carry/push/pull any weight whatsoever. At the same time, the FCE itself does not specify restrictions in this case in a normal fashion, per the Arbitrator's experience, and neither does Dr. Newell with regard to the FCE. The report itself noted at least some degree of question with regard to the reliability of Petitioner's subjective pain complaints, both with McGill and Oswetry evaluations.

Counselor Weber testified on cross examination that only 20% of jobs fall into the sedentary category, and that Petitioner had other aspects of her overall picture which limited her job market even further. At the same time, it appears that Marion, Illinois is one of the better markets in the Southern Illinois area, and that is where the Petitioner lives. More importantly in this case, the Arbitrator finds that the Petitioner failed to provide reasonable effort with regard to the vocational rehabilitation process, and that this lack of effort significantly impaired whatever chances she had of obtaining employment within her restrictions.

The Arbitrator finds that the Petitioner has failed to fulfill the burden of proof of showing that she cannot perform any job other than that for which no reasonably stable labor market exists. The Arbitrator acknowledges that the Petitioner testified that she was not a good student in high school. However, she indicated that she is a

high school graduate, and there was no evidence that she required special classes of any sort. The Petitioner testified to numerous problems participating in the vocational rehabilitation process, often involving computer use. The Arbitrator believes that, based on the preponderance of the evidence, the Petitioner did not provide a fair and sincere effort to participate in either retraining or the actual job search process. Thus, while her labor market was clearly limited by her injury, she has failed to show that no reasonably stable labor market exists for her in a sedentary position.

This Arbitrator finds the evidence and testimony supplied by counselor Weber was persuasive and credible based on her experience and numerous personal interactions with Petitioner over more than eighteen months. Ms. Weber was able to explain the timeline and her reasoning clearly, and it was supported by her contemporaneous reports. The testimony given by Petitioner was often based on generalities and assumptions, such as her testimony that she believed she completed 98% of the required tasks. A review of the vocational reports of counselor Weber reflect repeated failures to comply with the required tasks. The Petitioner's own testimony at times evidenced a lack of commitment and a belief that her role in the process was to just do the minimum she was required to do, and the vocational reports show that she often failed to even do the minimum. While the Arbitrator is certain that some of the Petitioner's excuses for her lack of completion were valid, including some issues with her health and the death of a sibling, the sheer number of them does not reflect well on her veracity. She postponed her initial meeting with Weber twice, allegedly due to car trouble. A rough draft of a resume was requested from her several times. She would indicate that her sister had it on her computer. Petitioner indicated several times she would provide it, then would fail to do so. She would wait until the last minute to sign up for college courses. She was shown how to use the computer to apply for positions numerous times, yet would repeatedly complain about having the same issues with applications despite being instructed on how not to complete the process. She was unable to provide proof of a significant number of alleged applications. The Petitioner continued to use an iPhone and her personal email account despite being instructed several times by Weber that she should be using a computer, which was available at a library 10 minutes from her home. This also would have allowed her to practice her computer skills. She then purchased a computer for her home, and still had the same issues. The Arbitrator agrees with the testimony of counselor Weber that the Petitioner's efforts in her job search essentially involved going through the motions and doing as little as she had to do. Most indicative of this is the Petitioner's testimony that she spent an average of three hours per week in the job search. There is credible evidence in the record that the Petitioner would wait until the last minute before doing her job search activities. The Petitioner's complaints of how "time consuming" it was to try to find work within her restrictions is baffling to the Arbitrator given the amount of time she appears to have put into the process.

With regard to the Petitioner's indications that she didn't know she was supposed to do various things as part of the vocational process, the Arbitrator finds the Petitioner was not credible. The testimony of Weber made it quite clear that the Petitioner was informed of what she was supposed to do numerous times, and simply was not making the effort necessary to give herself the best chance of finding employment. As noted by counselor Stefseth, the process of vocational rehabilitation is essentially a full time job. Three ours per week is a clear lack of reasonable effort. The Arbitrator believes the evidence supports that the Petitioner was not the best student and had a level of difficulty in terms of working with a computer and the job search tasks, but the evidence also supports a significant lack of effort by the Petitioner to overcome these obstacles..

There is always the possibility that the Petitioner just found the process of obtaining a job to be too difficult, and that she just was going to have difficulty using a computer regardless of how much training she received. Here, the Arbitrator finds that there are too many references and inferences which the Arbitrator believes shows a lack of effort and sincerity in the process from Petitioner, and this makes any fair determination with regard to her ability to learn impossible via a preponderance of the evidence. The Arbitrator recognizes that the process of vocational rehabilitation can be frustrating and involve a prolonged lack of success, but a Petitioner has the

responsibility to give her best effort just as the Respondent does, and in this case it appears to the Arbitrator that Ms. Weber went over and above to provide the Petitioner with assistance, and oftentimes the benefit of the doubt in this case. While Ms. Stafseth testified that Vocamotive would have provided more intensive assistance to the Petitioner in both training and the job search, the claimant should not require hand-holding in order to provide effort in looking for work and in the desire to return to work. In the Arbitrator's view, that just didn't happen here. There was no evidence presented that the Petitioner had any sort of learning disability or explanation for why she was not picking up on how to perform her required vocational tasks, and as noted, the evidence does repeatedly reflect a lack of full compliance on the part of Petitioner. The Arbitrator, in fact, believes that Ms. Weber's testimony and reports were often more kind and deferential to Petitioner than she sometimes deserved based on the facts indicated with regard to her failures to comply with the required tasks. Additionally, the Arbitrator notes that the Petitioner has clearly been able to obtain many jobs in a variety of fields without the assistance of vocational rehabilitation, and this is another factor the Arbitrator believes shows the Petitioner did not put her best foot forward to obtain employment in this case.

Cutting the other way, case law indicates that a failed job search is not a prerequisite to the ability to obtain an award of permanent total disability, but rather is a factor to be considered. Thus, the fact that the Arbitrator determined that the Petitioner gave a poor effort to the job search does not automatically mean she is employable. The factors enunciated by our Supreme Court must be reviewed.

With regard to age, the Petitioner was 46 years old at the time of the accident and 51 years old at the time of hearing. Counselor Weber has testified that Petitioner's age could be a negative factor for her in a job search. Counselor Stafseth opined that Petitioner's age wasn't a big factor in her employability. The Arbitrator does not believe the Petitioner's age at the time of hearing, or her age when she began her failed job search, indicates she is permanently disabled. Her work experience, according to the reports of Weber and Stafseth, is varied and certainly indicative of a person who has been able to find employment. She is a high school graduate and a member of the operator's union, which indicates to the Arbitrator that she has not had prior problems with learning and moving successfully into different jobs. While the Arbitrator notes that both Dr. Newell and Dr. Lee have indicated the Petitioner needs significant restrictions, the Arbitrator believes that the Petitioner's FCE, indicating some level of psychosocial pain issues.

Based on the above, the Arbitrator finds the Petitioner has failed to prove she is permanently and totally disabled as a result of the 10/27/11 accident. According to current case law, the next inquiry that must be made is whether sufficient evidence was presented to support a wage differential claim pursuant to Section 8(d)1 of the Act.

The Arbitrator notes that the Job Description (Rx6) and "Demands of the Job" (Rx7) documentation provided by Respondent with regard to the Petitioner's job as a Maintenance Equipment Operator clearly indicate that the Petitioner is not employable in that position based on her current work restrictions. While she only worked for the Respondent for a short time, her job before that was a heavy equipment operator, and it is clear that such a job is not sedentary. Thus, the evidence supports the finding that the Petitioner is unable to return to her usual and customary work due to the 10/27/11 accident.

The next inquiry pursuant to Section 8(d)1 is the difference between the average amount the Petitioner would be able to earn in the full performance of her regular job and the average amount she is earning or able to earn in some suitable employment after the accident.

The only evidence in the record which supports what the Petitioner would be able to earn in the full performance of her duties is the average weekly wage of $749.85. As the Petitioner remains unemployed, there is no evidence which indicates what she is earning in suitable employment. The Arbitrator relies upon and finds persuasive the

testimony of Ms. Weber, which indicated her opinion that Petitioner is capable of earning essentially the minimum wage of $8.25 or slightly more. Her LMS indicated that of the available full and part time jobs she was able to locate, the salaries ranged from $19,240 to $32,926 per year, or $9.25 per hour to $15.83 per hour. Several of the noted positions, which admittedly indicated the need for some computer experience, had a low end starting wage of $9.92 to $10.00 per hour. The Arbitrator notes that some of these positions clearly required additional training, but the Arbitrator believes the Petitioner had plenty of opportunity to take advantage of the minimal amount of training needed to obtain basic computer skills, and that Respondent provided significant effort to assist her. The only potential job listed in the LMS prepared by counselor Stafseth which listed a starting salary range indicated a range from $10.00 to $11.00 per hour as a full time scheduler. The Arbitrator finds that the preponderance of the credible evidence in this case leads to a reasonable conclusion that the Petitioner was capable of obtaining a job at the lower end of this scale, $10.00 per hour, or $400.00 per week.

The Arbitrator finds that the Petitioner has proven entitlement to benefits under Section 8(d)1 of the Act. Pursuant to same, the Petitioner is entitled to $233.23 per week for the duration of her disability, or age 67, whichever comes first.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that, based on a review of the stipulation sheet (Arbx1) and the parties' statements of exception, the stipulated $77,201.99 credit is applicable to the period of maintenance that the Arbitrator has awarded. It is clear that the Petitioner was entitled to TTD from 10/28/11 through 9/6/13, and that this was paid by Respondent, and thus there was no claim for benefits and no claim for credit applicable to this TTD period.

WITH RESPECT TO ISSUE (O), THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has failed to prove that she is entitled to costs associated with vocational rehabilitation services, namely mileage costs for her travel to the Shawnee and John A. Logan schools. The Arbitrator finds that the Petitioner has failed to show entitlement to same. Evidence in the record indicates she would drive back and forth to Carbondale for work with the Respondent. There is no evidence the Petitioner was not paid her weekly benefits during this time, other than when the Respondent terminated them based on a determination of a failure to comply. There is nothing unreasonable about the Petitioner incurring the costs of this drive when it was significantly less than what she would have driven in a full time job with Respondent. Additionally, as the Arbitrator noted above, the Petitioner's true effort was lacking for the most part with regard to her registration and performance in the classes. The Petitioner's claim for travel costs is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Howard,

Petitioner,

vs.

NO: 14 WC 31842

18IWCC0424

University of Illinois,

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 all issues, and being advised of the facts and law, modifies the Decision of the Arbitrator and finds Petitioner's diagnoses only relating to Petitioner's right shoulder and left foot and ankle are causally related to the July 31, 2014, work accident. However, the Commission finds Petitioner's possible diagnosis of Horner syndrome or Bell's palsy is not causally related to July 31, 2014, work accident. The Commission also finds that Respondent is liable for Petitioner's travel expenses for treatment with Dr. Romeo only when treatment with Dr. Romeo is the sole cause of Petitioner's travel. 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).

Findings of Fact

In the interest of efficiency, the Commission primarily relies on the Arbitrator's detailed recitation of facts. On July 31, 2014, Petitioner sustained injuries as a result of a fall at work. Petitioner testified that while walking with a coworker to another site, Petitioner tripped on uneven pavement and rolled her left ankle. (Tr. at 9). Petitioner landed on her right elbow. She testified that the instep of her left foot rolled up and touched the inside of her calf. *Id.* Petitioner sustained injuries to her left ankle and right shoulder.

Petitioner visited the ER on the date of accident. (PX 2). She reported falling at work due to uneven pavement and complained of a right elbow abrasion, right shoulder pain, left ankle pain, and decreased sensation on bottom of the left foot. X-rays of the right shoulder and elbow were

normal. The left ankle x-ray revealed a well-defined 8mm bone fragment adjacent to the tip of the lateral malleolus compatible with old remote trauma as well as a mild hallux obvious deformity. *Id.* The doctor prescribed a splint and crutches for Petitioner's left ankle pain. Petitioner began treating with Dr. Cohen, a family medicine doctor, in August 2014. In late August, Dr. Cohen diagnosed a left ankle sprain, left ankle pain with bony prominence in the sinus tarsi, old distal fibular avulsion fracture, and right shoulder rotator cuff sprain.

Dr. Grambart, a podiatrist, first examined Petitioner on September 4, 2014. *Id.* He suspected Petitioner's left foot and ankle complaints were due to nerve pain and ordered an MRI. He referred Petitioner to a pain specialist. Dr. Rauther, a pain management doctor, examined Petitioner on September 24, 2014. *Id.* Regarding Petitioner's left foot and ankle complaints, Dr. Rauther diagnosed neuralgia/neuritis, old remote trauma with bone fragment adjacent to the lateral malleolus, and questionable CRPS. *Id.* The doctor believed there was a definite nerve-related pain component to Petitioner's severe left foot and ankle complaints. She referred Petitioner to Dr. Lubenow, a pain medicine doctor at Rush University, at Petitioner's request. A September 30, 2014, MRI of the left ankle revealed fibers of the anterior talofibular ligament appearing indistinct, possibly the result of a prior sprain or partial tear.

Dr. Gurtler, an orthopedic surgeon, examined Petitioner's right shoulder on October 23, 2014. *Id.* Dr. Gurtler noted that while Petitioner's October 16, 2014, right shoulder MRI showed no convincing rotator cuff tear, it did show some superior labral tears and a bright collection in the anterior superior labrum measuring 12 x 8 x10 mm consistent with a paralabral cyst. *Id.* Dr. Gurtler suspected possible CRPS in the right arm and recommended Dr. Lubenow treat Petitioner for both her left foot and ankle and her right arm. *Id.*

Dr. Lubenow first examined Petitioner on December 11, 2014. (PX 3). He diagnosed CRPS of the left lower extremity with a suspected peroneal neuropathic pain component and right upper extremity brachial plexopathy with a right shoulder labral tear. *Id.* He ordered an EMG of the right arm and left leg and scheduled Petitioner for a series of lumbar sympathetic blocks to aggressively treat her left foot CRPS. *Id.* That same month, Dr. Gurtler and Petitioner discussed his concerns regarding Petitioner's complex shoulder issues via telephone. (PX 2). Dr. Gurtler recommended Petitioner see a shoulder specialist. *Id.*

Dr. Lubenow performed six lumbar sympathetic blocks between January 2015 and December 2015 with good results overall. (PX 3). A January 21, 2015, EMG/NCS of Petitioner's right arm and left leg was normal with no evidence of a neuropathic process. (PX 2). On January 22, 2015, Dr. Grambart performed a manipulation of the left ankle under anesthesia and a steroid injection. *Id.* The postoperative diagnoses were a left ankle injury and chronic nerve pain. Despite reporting some initial improvement, Petitioner's pain quickly returned to her pre-surgery baseline. A February 2015 bone scan revealed no evidence of abnormal ankle uptake. Petitioner continued to follow up with Drs. Grambart and Lubenow as well as her PCP throughout 2015. Dr. Grambart performed platelet-rich plasma ("PRP") injections into the superficial peroneal nerve on April 21, 2015, June 25, 2015, and October 1, 2015. *Id.*

Dr. Romeo, an orthopedic surgeon, examined Petitioner on October 12, 2015. (PX 4). Petitioner arrived in a wheelchair and was wearing a walking boot on the left foot and a sling on

her right arm. *Id.* She stated that she was unable to perform any activity with her right arm. Dr. Romeo noted Petitioner had significant pain with any palpation to her shoulder. He noted that Petitioner winced with pain and nearly jumped out of her wheelchair. Dr. Romeo told Petitioner that no surgical intervention would significantly improve her condition. He referred her to Dr. Lubenow for pain management relating to Petitioner's right shoulder complaints. *Id.*

Petitioner underwent two right stellate ganglion blocks as well as a lumbar block in December 2015. (PX 3). Petitioner subsequently possibly developed Horner syndrome following the second ganglion block injection. Petitioner followed up with Dr. Lubenow in January 2016. *Id.* He advised Petitioner to visit Dr. Grambart for a determination regarding the necessity of surgery for the left foot and ankle. *Id.* Dr. Lubenow determined that Petitioner's pain treatment relating to the right shoulder was complete and she should see Dr. Romeo for another orthopedic evaluation. Finally, Dr. Lubenow stated, "there is no medical reason for horner's (sic) syndrome this far removed from SGB, except anxiety component." *Id.*

On February 3, 2016, Petitioner visited Dr. Khosrowshahi, a neurologist, and complained of continued symptoms relating to her possible diagnosis of Horner syndrome. (PX 2). Dr. Khosrowshahi determined that Petitioner's complaints of ongoing facial weakness were unrelated to any diagnosis of Horner syndrome and believed Petitioner was malingering. *Id.* On February 9, 2016, Dr. Aronson provided a second neurology opinion. He did not believe Petitioner had Horner syndrome or any persisting symptoms relating to her stellate block. He also determined that Petitioner had no cervical radiculopathy or myelopathy. Petitioner last visited Dr. Lubenow on March 23, 2016. (PX 3).

An April 2016 MRI of the left ankle revealed an intact anterior talofibular ligament inserting on an avulsion fracture fragment from the tip of the lateral malleolus which may be ununited. (PX 2). The study also revealed a mildly increased signal within the peroneus longus tendon along the lateral aspect of the calcaneus consistent with mild tendinosis. In May 2016, Petitioner continued to complain of left foot and ankle pain and instability as well as nerve pain. Dr. Grambart recommended surgery but cautioned against removing the nerve. *Id.* On June 15, 2016, Dr. Grambart performed surgery consisting of excision of bone fragment lateral malleolus with advancement and repair with reattachment of the anterior talofibular ligament and excision of benign bone fragment anterior process calcaneus. *Id.* The postoperative diagnoses were: 1) fracture fragment distal fibula; 2) ankle instability; 3) bone prominence anterior process calcaneus; and 4) chronic regional pain syndrome. *Id.*

A December 2016 MRI of the left foot revealed: 1) interval postoperative changes related to fragment removal and ATFL; and 2) abnormal appearance of the peroneal tendons with poor separation with probable partial tearing of the brevis and tendinosis of the longus. A January 2017 ultrasound of the foot revealed a probable longitudinal tendon tear within the peroneal longus tendon. *Id.*

Dr. Grambart recommended a second ultrasound with a more sensitive machine to confirm the possible tendon tear. *Id.* He noted that Petitioner continued to wear a boot because she reported increased pain with the AFO brace. In March 2017, Dr. Grambart noted the peroneal tendons appeared fine on the repeat ultrasound; however, there was a question of some nerve irritation. *Id.*

He did not believe a sural neurectomy would provide any benefit; instead, Dr. Grambart recommended that Petitioner return to Dr. Lubenow and see a peripheral nerve specialist.

Expert Medical Reports and Testimony

Dr. Gregory B. Holmes, Jr. – Respondent IME

Dr. Holmes, an orthopedic surgeon, examined Petitioner's left ankle on January 28, 2015. (RX 4). After reviewing the medical records and examining Petitioner, Dr. Holmes opined that Petitioner did not have CRPS. He opined that while there may be some neurologic component to Petitioner's pain, the absence of disuse atrophy of the left foot called into question any diagnosis of CRPS. Dr. Holmes also noted that the physical findings of his exam were "far better than could have been anticipated with the clinical history." He did not believe the objective data correlated with Petitioner's subjective complaints.

Dr. Holmes noted that Petitioner had an extensive medical history of allergies and exposures to medications and various medical conditions which may "somewhat peripherally be contributing to her subjective complaints of pain." He did not believe the examination under anesthesia was reasonable and necessary given the MRI findings. He opined that there was no need to remove the bone fragment because there was no objective evidence that the bone fragment was dislodged, aggravated, or injured further due to the work injury. Dr. Holmes believed it was reasonable to continue some facets of pain management for developing systems to handle her pain. He opined that from an orthopedic standpoint, Petitioner did not have any restrictions and did not sustain "any life-altering injuries or sustained any musculoskeletal trauma of significance to her ankle." *Id.* He placed Petitioner at MMI from an orthopedic standpoint. He recommended a second opinion regarding whether Petitioner was at MMI regarding her pain syndrome.

Dr. Holmes testified via evidence deposition on May 15, 2017. (RX 5). Dr. Holmes testified that the examination under anesthesia was unnecessary because Petitioner's MRI did not show any significant ligamentous injury that would warrant that procedure. *Id.* at 21. He also testified that the bone fragment did not require removal because it was old at the time of the work accident and "if there had been some aggravation of the bone fragment as a result of the injury, it would have also shown up on the MRI as some collateral damage." *Id.* Dr. Holmes believed Petitioner's complaints of pain were more neurological than CRPS. *Id.* at 28.

Dr. Kaylea Boutwell – Respondent IME

Dr. Boutwell, a pain management specialist, examined Petitioner on April 24, 2015. (RX 6). Petitioner reported experiencing temporary relief from the initial sympathetic nerve block Dr. Lubenow performed. She complained of constant pain in both her right arm and left foot. Petitioner also complained of swelling in the left foot. Dr. Boutwell concluded that Petitioner did not have CRPS of the right arm. Instead, she diagnosed "a combination of pathology consisting of inflammatory and neuropathic pain related to intrinsic right shoulder joint pathology, as well as a potential contribution of a right brachial plexus abnormality consistent with her history of mechanical trauma." *Id.* She questioned the diagnosis of CRPS of the left foot and ankle due to the normal bone scan and the lack of significant atrophy of Petitioner's left foot which was

inconsistent with disuse atrophy. She opined that Petitioner's medical treatments, other than the examination under anesthesia, were reasonable and necessary. Dr. Boutwell recommended Petitioner see a shoulder specialist to treat her potential brachial plexopathy type injury. As she ruled out CRPS of the right arm, Dr. Boutwell opined that there were no impediments to proceeding with any necessary surgery to improve the right shoulder. Dr. Boutwell strongly questioned the diagnosis of CRPS of the left foot and ankle, and recommended a second sympathetic nerve block. She opined that additional blocks should only occur if the second nerve block resulted in significant improvement in Petitioner's condition and pain.

Dr. Boutwell testified via evidence deposition on September 7, 2016. (RX 7). Dr. Boutwell testified regarding the results of her physical examination including the fact that the capillary refill on both the left and right feet was brisk and symmetric. She testified, "So whatever might have been going on from a sympathetic nervous system or vascular standpoint, had at a minimum to have a reversible component that wasn't present when I was examining her, nor were there signs of that type of problem being overtly chronic." *Id.* at 23. She testified that a negative EMG/NCS and negative three-phase bone scan argue strongly against the diagnosis of CRPS. *Id.* at 27. Dr. Boutwell explained how she used the Budapest Criteria when reaching her conclusions regarding Petitioner's questionable CRPS diagnosis. *Id.* at 31-36. She opined that it is possible that Petitioner exists on the "very, very, very mild" end of CRPS in her left foot and ankle. *Id.* at 37. Dr. Boutwell testified, "I believe that she more likely had an underlying probably vasomotor dysfunction similar to what she had in the right hand, which I don't believe was related to the injury, and had some persistent neuritis of some sort in the area that potentially, you know, caused those vasomotor changes to become more significant." *Id.*

Dr. Boutwell testified that if medical records show that Petitioner walked with a normal gait, she would completely rule out a diagnosis of CRPS. She testified that given the negative objective diagnostic studies, if Petitioner underwent additional blocks without improvement of her discomfort or a normal relation of temperature, "that's when you call it a day, that it's unlikely that whatever complaints she's reporting subjectively are the results of an objectively verifiable diagnosis." *Id.* at 48-49. Dr. Boutwell testified that Petitioner was not overreacting during physical exam and did not have positive Waddell signs. *Id.* at 51. She testified that she focused on the accumulative effect of the condition because CRPS symptoms can wax and wane. *Id.* at 57-58.

Dr. Mitchell Rotman – Respondent IME

Dr. Rotman, an orthopedic surgeon, examined Petitioner's right arm and shoulder on May 9, 2016. (RX 2). Petitioner reported she sustained tears in her biceps, cysts, muscle problems, CRPS, thoracic outlet syndrome, and a rotator cuff tear due to the work accident. *Id.* Dr. Rotman noted that Petitioner was already taking numerous medications prior to the work accident, including Cymbalta, Flexeril, Norco, and Diazepam. Dr. Rotman also reviewed IME reports by Dr. Boutwell and Dr. Holmes. He determined Petitioner did not suffer from frozen shoulder because she had symmetric external rotation on the right and left. Dr. Rotman also noted Petitioner met each maneuver where he asked her to create resistance with obvious weakness and decreased effort. He also noted a multitude of non-physiologic responses with palpation over various areas of the right arm.

Dr. Rotman opined that Petitioner had no evidence of RSD in the right arm. He opined she had a normal functioning right arm based on objective findings. He stated, "The multitude of non-physiologic responses or obvious give way weakness throughout the exam suggest that her subjective complaints are not at all reliable." He pointed to the bone scan that showed no evidence of an injury to the right ankle stating, "If she were to have had a significant sprain or any type of fracture, her bone scan would have been hot for at least a year." Dr. Rotman also did not find evidence of a superficial peroneal nerve injury and noted Petitioner's normal EMGs of her right shoulder and left ankle. He believed almost all her treatment was unnecessary given the lack of objective findings. He opined that Petitioner should have been able to return to work within a week of the work accident. Dr. Rotman noted that he did not examine Petitioner's left foot, but based his opinions regarding her left foot complaints on the x-rays, medical records, and bone scan. He stated, "Even though I am not a specialist in the treatment of lower extremity issues, I still am very aware of how to make a diagnosis of a foot and ankle condition, especially a sprain or a fracture or a nerve injury." Dr. Rotman placed Petitioner at MMI.

Dr. Rotman testified via evidence deposition on September 6, 2016. (RX 3). Dr. Rotman testified a bone scan is one of the best tests to prove RSD and is also a good test to show an injury. *Id.* at 13. He testified that most labral tears are asymptomatic and can later become symptomatic usually because of rotator cuff problems. *Id.* at 28-29. He agreed that trauma could be an instigating factor making a tear symptomatic. *Id.* at 30. Dr. Rotman has some experience treating patients with CRPS. *Id.* at 32-33. Dr. Rotman testified that usually CRPS resolves with intense therapy. *Id.* at 34. He testified that the symptoms of CRPS typically do not wax and wane; instead, usually someone has it and then the condition improves. *Id.*

Dr. Timothy Lubenow – Treater

Dr. Lubenow testified via evidence deposition on January 4, 2017. (PX 3). Dr. Lubenow testified that in December 2014 he diagnosed Petitioner with CRPS of the left lower extremity with a suspected peroneal neuropathic pain component. *Id.* at 13. He also diagnosed a right upper extremity brachial plexopathy with a right shoulder labral tear. *Id.* Dr. Lubenow was part of the group of doctors who developed the Budapest Criteria. The doctor testified that it is the acceptable standard for diagnosing CRPS. *Id.* at 36. He testified that the antecedent event to CRPS is usually some type of trauma. *Id.* Dr. Lubenow testified that sympathetic blocks are therapeutic and are no longer used as a diagnostic tool. *Id.* at 21. He believed Petitioner responded positively to the sympathetic blocks he performed in October 2015. *Id.* at 22. The doctor testified that a stellate ganglion block can produce Horner syndrome; however, it is usually only present for four to six hours after the procedure. *Id.* at 25. He testified that there was no medical reason for Petitioner's ongoing complaints of Horner syndrome. *Id.* at 26. Dr. Lubenow testified that Petitioner requires additional treatment to improve her pain so that she would not have to take opiate medications and could improve her functional well-being regarding the left foot and ankle. *Id.* at 30.

Dr. Anthony Romeo – Treater

Dr. Romeo testified via evidence deposition on October 26, 2016. (PX 4). He examined Petitioner only on October 12, 2015. *Id.* Dr. Romeo told Petitioner no surgery would make her

significantly better because her pain was out of proportion to any of the potential problems with her shoulder. *Id.* at 10. He testified that the most common shoulder injuries resulting from a fall on an outstretched hand are labral and rotator cuff tears. *Id.* at 13. He opined that Petitioner's July 2014 fall rendered Petitioner's shoulder condition symptomatic. *Id.* at 14. Dr. Romeo testified that he could not recommend any surgery without conducting another evaluation of Petitioner. *Id.* at 17. He testified that he did not make any comments about symptom magnification in his office visit note because, "Patients that truly have a brachial plexopathy or severe chronic regional pain syndrome are people that share with us that they have the worst pain they have ever experienced in their life." *Id.* at 18. He further testified that he did not know "how you can magnify something that is known to be some of the most horrific pain that people can experience." *Id.* On cross-examination, Dr. Romeo testified that there has not yet been a clear orthopedic diagnosis regarding the right shoulder because the treatment thus far has related to a problem that is more neurologic, not orthopedic, in nature. *Id.* at 21. He testified that one rarely, if ever, sees atrophy or wasting away of the arm due to nonuse unless there is a complete neurologic injury where the nerve has been severed. *Id.* at 24-25.

Dr. Sean Grambart – Treater

Dr. Grambart testified via evidence deposition on August 26, 2016. (PX 5). Dr. Grambart testified that he recommended a manipulation with sedation to better assess the left ankle ligaments. *Id.* at 12. He opined sedation with manipulation was necessary due to Petitioner's complaints of extreme pain. *Id.* at 13. When a patient is sedated, Dr. Grambart can get a more accurate read of the ligaments because the patient is not guarding against the stress exam. *Id.* Petitioner's response, or lack thereof, to the steroid injection revealed there was no impingement or joint problems; instead, the doctor believed nerve pain was the cause of Petitioner's complaints. *Id.* at 14. Dr. Grambart testified that the PRP injections were attempts to try to stimulate healing around the nerve. *Id.* at 15. He admitted the PRP injections made no significant improvement in Petitioner's pain. *Id.* at 17.

Dr. Grambart examined Petitioner in May 2016 and noted she still had hypersensitivity along the nerve and that the sural nerve was still tender on the tip of the fibula. *Id.* at 21. Dr. Grambart noted some atrophy of the calf muscles and noted Petitioner's toes were developing extension deformities and were starting to pull up. *Id.* Dr. Grambart testified that the June 2016 ankle surgery was necessary because Petitioner still had persistent pain and a feeling of instability in the ankle. *Id.* at 18-19. He testified that the June 2016 surgery was also necessary because Petitioner still had pain along the tip of the fibula and the fracture fragment piece was still ununited. *Id.* at 23. He testified that his plan is to get Petitioner moving on the left foot to try to prevent any permanent nerve irritation. *Id.* Dr. Grambart would also like to have Petitioner begin physical therapy. He also recommended that Petitioner follow up with Dr. Lubenow. *Id.*

Conclusions of Law

After carefully considering the totality of the evidence, the Commission modifies the Arbitrator's award regarding the causal relation of Petitioner's current condition of ill-being. The Commission also modifies the Arbitrator's award of travel expenses for Petitioner's visits for treatment with Dr. Romeo. The Commission affirms and adopts the remainder of the Arbitrator's

Decision. 18IWCC0424

The Arbitrator correctly concluded that Petitioner's current condition of ill-being regarding her left ankle and foot and her right shoulder is causally related to the July 31, 2014, work accident. Both parties submitted expert medical opinions in the form of IME reports and testimony. The Commission finds the credible evidence does not support Respondent's argument that the condition of Petitioner's left foot and ankle after January 28, 2015, is not causally related to the work accident. Likewise, The Commission also rejects Respondent's argument that the condition of Petitioner's right shoulder after February 16, 2015, is not causally related to the work accident.

The Commission finds that Petitioner failed to meet her burden of proving by a preponderance of the evidence that any complaints and medical treatment related to her possible Horner syndrome or Bell's palsy diagnosis causally relate to the work accident. A careful review of the medical records reveals that no doctor determined Petitioner's complaints relating to her possible diagnosis of Horner syndrome or Bell's palsy relate in any way to the stellate ganglion blocks Petitioner underwent in December 2015. Dr. Lubenow testified that there was no medical reason for Petitioner's ongoing complaints of Horner syndrome. He also testified that Petitioner's complaints were not related to the December 2015 stellate ganglion blocks. Therefore, the Commission finds that Respondent is not responsible for any medical treatment or complaints related to Horner syndrome or Bell's palsy.

Finally, the Arbitrator determined Petitioner is entitled to all travel expenses relating to her past and future treatment with Dr. Romeo. The Commission finds that Petitioner is entitled to travel expenses for medical treatment with Dr. Romeo only when that treatment with Dr. Romeo is the sole reason for her travel. Both Dr. Lubenow and Dr. Romeo are treating Petitioner in the Chicago area. While one of Petitioner's doctors referred her to Dr. Romeo given the complexity of her right shoulder injury, there is no dispute that Petitioner independently chose to begin treatment with Dr. Lubenow for her CRPS and pain management. Thus, Petitioner is not entitled to travel expenses relating to any treatment with Dr. Lubenow. To date, Petitioner has only visited Dr. Romeo once, on October 12, 2015. However, a review of the medical records shows Petitioner did not solely see Dr. Romeo on that day. Instead, Dr. Lubenow also performed a lumbar sympathetic block that same day. As Petitioner would have already been in Chicago to undergo treatment with Dr. Lubenow, she is not entitled to travel expenses for her October 12, 2015, trip.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2017, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being relating to her left foot and ankle and right shoulder is causally related to the July 31, 2014, work accident. Petitioner's complaints and medical treatment relating to her possible diagnosis of Horner syndrome or Bell's palsy are not causally related to the work accident.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical charges that relate only to treatment for Petitioner's left foot and ankle and right shoulder, as

provided in Sections 8(a) and 8.2 of the Act and per the stipulation of the parties. Respondent is not liable for charges relating to Petitioner's possible diagnosis of Horner syndrome or Bell's palsy. Respondent shall receive a credit for any amounts paid pursuant to Section 8(j).

IT IS FURTHER ORDERED that Petitioner is entitled to travel expenses for visits with Dr. Romeo only when treatment with Dr. Romeo is the sole cause of Petitioner's travel. Petitioner is not entitled to travel expenses relating to her October 12, 2015, appointment with Dr. Romeo.

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

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

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

DATED: JUL 10 2018

o: 5/14/2018
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

HOWARD, LAURA
Employee/Petitioner

Case# **14WC031842**

UNIVERSITY OF ILLINOIS
Employer/Respondent

18IWCC0424

On 8/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1727 LAW OFFICES OF MARK N LEE LTD
KEVIN MORRISSON
1101 S SECOND ST
SPRINGFIELD, IL 62704

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

1073 UNIVERSITY OF ILLINOIS
100 TRADE CENTER DR
SUITE 103
CHAMPAIGN, IL 61820

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

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

AUG 29 2017

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

18IWCC0424

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Laura Howard
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # **14 WC 031842**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **June 15, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **7/31/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$55,941.31**; the average weekly wage was **$1075.80**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **2** dependent children.

Petitioner has not received all reasonable and necessary medical services.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services found in Petitioner exhibit 6, as provided in Sections 8(a) and 8.2 of the Act and per the stipulation of the parties, subject to any credit pursuant to Section 8(j).

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the proposed referrals by Dr. Grambart, consultation with Dr. Romeo and his treatment recommendation, and consultation with Dr. Lubenow and his treatment recommendation.

Respondent shall pay Petitioner temporary total disability benefits of $717.56/week for 150 weeks, commencing 8/1/2014 through 6/15/2017, as provided in Section 8(a) of the Act subject to the credit established by Respondent.

Petitioner is entitled to travel expenses for her 10/20/2015 visit with Dr. Romeo and future treatments.

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.

Earl Lee
Signature of Arbitrator

8/27/17
Date

ICArbDec19(b)

AUG 29 2017

STATEMENT OF FACTS 18IWCC0424

Petitioner's Testimony

Petitioner is employed as a civil engineer as a facility operations manager for Respondent. (T.6) On July 31, 2014, Petitioner fell and got injured at work. (T.8) Petitioner was walking to another site with another manager and where the two sections of pavement are seamed together there was a difference in elevation and her ankle rolled and she fell. (T.8) When Petitioner fell, she came across her body with a right upper extremity and landed on her right elbow. (T.8) Petitioner's left ankle tripped and rolled when she fell. (T.9) After the accident, Petitioner noticed her left foot and ankle were extremely swollen. (T.11) She was also having some difficulty with her right shoulder and elbow. (T.11)

Dr. Gurtler sent Petitioner to see Dr. Romeo as Dr. Gurtler thought Dr. Romeo would be better able to handle her claim. (T.17)

On October 16, 2015, Petitioner went to Carle Emergency Room after she got in a fight with her husband and Petitioner complained that he hurt her right shoulder. (T.18) Petitioner testified her pain went back to what it was before. (T.19) Petitioner did not seek any additional treatment for her right shoulder as a result of that injury. (T.19)

Petitioner also fell down on January 2, 2016, when she fell down stairs. (T.19) Petitioner testified her ankle was still very unstable and the boot that she wore was very bulky and she tripped with her boot and then her ankle rolled somewhat inside of the boot. (T.19) Petitioner fell backwards and caught herself and her wrists were inverted as her hands were falling behind her to catch her and suffered additional injury to her left wrist. (T.20)

Petitioner did not recall ever being issued a mileage check for attendance of any of the Section 12 exams. (T.21)

Petitioner wants treatment with Dr. Grambart as he is looking at tendon ligament issues and possible removal of the peroneal nerve in her leg. (T.23) Dr. Lubenow wants to continue the sympathetic lumbar blocks in her spine and she wants to proceed with them. (T.24) Dr. Romeo has recommended a re-evaluation for surgery and she wants to proceed with that. (T.25) Dr. Grambart also recommends she see a peripheral nerve specialist if Petitioner wants to proceed with that. (T.25-26)

At trial, Petitioner testified she is not doing well. (T.26) Petitioner's toenails are turning black and her toes are turning purple. (T.26) There is crushing pain and some days are better than others and some days are worse than others. (T.26) Petitioner can be fine for a while and then all of a sudden she will lose feeling just maybe four or five inches below her knee and then midstride she can't feel her leg. (T.26) Petitioner testified she had very limited mobility in the right shoulder and still continued to have pain and loss of sensation and circulation. (T.27)

Dr. Grambart told Petitioner she could wear her boot as needed. (T.30) Petitioner testified she wore her boot the whole date of trial. (T.30) Petitioner would rate her pain as an 8.5/10 at trial. (T.31) Despite the pain Petitioner has, she is still able to wear the boot as she explained it provided stability and support. (T.31)

Petitioner testified she has not followed up with either Dr. Lubenow or Dr. Romeo because they are outside of her health insurance network and they will not see her without full payment. (T.17) Petitioner even attempted to return to Dr. Gurtler for a follow up but was, again, sent back to Dr. Romeo.

Medical Records

On July 31, 2014, Petitioner presented to Dr. Ferguson at Carle ER. (Px-2) Petitioner reported that she had fell on uneven pavement and fell onto her right elbow. Petitioner complained of injuries to her right elbow, right shoulder and left ankle. On exam, the left ankle and right elbow had decreased range of motion secondary to pain. She also had tenderness over the right AC joint. No cervical or lumbar spine tenderness. X-ray of the left ankle revealed no acute fracture or dislocation but there did appear to be an old injury at the lateral malleolus. X-rays of the right elbow and right shoulder showed no fracture or dislocation. Petitioner was diagnosed with a left ankle injury and right elbow injury. Petitioner was released with restrictions.

On August 5, 2014, Petitioner presented to Dr. Randy Cohen of Carle Department of Occupational Medicine. (Px-2) Examination of the left ankle revealed slight swelling of the lateral malleolus with prominent boney protrusion in the region of the sinus tarsi inferior to the lateral malleolus. Examination of the right elbow revealed healing abrasion without any signs of infection and full range of motion. Examination of the right shoulder revealed tenderness interiorly, laterally, subacromially and over the posterior aspect of the shoulder. Marked limitation of abduction and external rotation. No evidence of AC joint tenderness or clavicle tenderness. The left ankle was re-x-rayed which did not show any evidence of acute fractures. X-rays of the foot did not reveal any fracture of the fifth metatarsal or the fifth toe. The assessment was left ankle lateral malleolus sprain, left foot fifth toe sprain and contusion, right knee contusion, right elbow contusion and abrasion and right shoulder sprain. Petitioner was to continue to use an air stirrup splint and continue with crutches. Petitioner was taken off of work.

On August 7, 2014, Petitioner followed up with Dr. Nelson, her family doctor, with some improvement to her right shoulder but there was still a problem with abduction and internal rotation. (Px-2) Petitioner still had continued complaints of left foot and ankle with severe pain over the lateral ankle anterior to the malleolus, pain over the anterior of the foot, and over the 5th metatarsal into the Achilles.

On August 13, 2014, Petitioner presented to Dr. Cohen. (Px-2) Petitioner continued to have left ankle and right shoulder pain but her right elbow seemed to have improved. There was a discussion of Petitioner having regional pain syndrome in the left foot. Orthopedic referral made for the right shoulder. Petitioner was to remain off of work. Petitioner was to continue to use the splint and use crutches. Petitioner was to remain off of work.

On August 29, 2014, Petitioner to Dr. Cohen. (Px-2) Petitioner continued to have left ankle and right shoulder pain. Petitioner to continue to use splint and crutches. Petitioner was to remain off work.

On September 4, 2014, Petitioner presented to Dr. Grambart. (Px-2) Petitioner described her twisting mechanism injury to Dr. Grambart. Petitioner had pain to the lateral aspect of her foot and ankle, aching stabbing, pressure, radiating pain 7-8/10. Dr. Grambart reviewed the x-rays which showed a small avulsion fracture of the lateral cuboid. He recommended an MRI and thought Petitioner suffered from nerve pain. Dr. Grambart's assessment was a work related left ankle injury.

On September 5, 2014, Petitioner presented to Dr. Cohen. (Px-2) Petitioner continued to have right shoulder complaints for which she was scheduled to go to orthopedics. Petitioner was kept off work.

On September 11, 2014, Petitioner presented to Danny McFarland, PA of Carle Department of Orthopedics. (Px-2) Petitioner reported right shoulder pain with occasional tingling in her fingers. Attempts to maneuver Petitioner's arm brought Petitioner to tears. There was no overlying tissue erythema. Petitioner had good range of motion of the elbow though trying to extend the elbow fully seemed to hurt the shoulder. Petitioner able to move all fingers of her hand. The impression was right shoulder pain with some swelling with suspicion of torn rotator cuff. MRI was ordered. Petitioner kept off work.

On September 16, 2014, Petitioner returned to Dr. Cohen with left ankle problems, cold feet/ankle, numbness in some toes, and foot was white. (Px-2) Dr. Cohen noted Petitioner had left ankle trauma with possible avulsion fracture and what appeared to be regional pain syndrome. The feet are alternatively red, blue, and blanched.

On September 24, 2014, Petitioner presented to Dr. Shabeera Rauther of Carle Department of Interventional Pain at the referral of Dr. Grambart. (Px-2) Petitioner presented with complaints of left foot and ankle pain. Petitioner rated her pain on an 8.5/10 with her best being a 6.5/10. Petitioner described a constant burning sensation with pins and needles. Her left foot and ankle constantly felt cold. Petitioner reported from time to time the foot turned white, red and purple. Petitioner reported weakness using the left ankle as well as numbness along the middle three toes. On exam, there was no skin, hair or nail changes. Good capillary refill over the left foot with no temperature differences between the two sides. There was some allodynia over the lateral aspect closer to the malleolus. Some sensory deficit along the middle three toes. Range of motion of the left ankle was markedly diminished. No swelling or skin discoloration compared to the opposite side. The diagnosis was neuralgia/neuritis, old remote trauma with bone fragment adjacent to the lateral malleolus with questionable complex regional pain syndrome. Dr. Rauther was not clear if this was complex regional pain syndrome or not. Dr. Rauther did not notice any clinical signs consistent with CRPS on exam. Petitioner was informed that if she noticed any color changes or swelling that she should take pictures of it on her phone so it could be seen. Dr. Rauther believed there was some nerve related pain component. It was noted Petitioner was taking quite a bit of hydrocodone that she was obtaining from different providers at different times. Petitioner was informed to stick with one provider and have a pain agreement with him. Petitioner requested a referral to Dr. Lubenow at Rush University.

On September 26, 2014, Petitioner presented to Dr. Cohen. (Px-2) Petitioner presented with continued complaints of the left ankle and right shoulder. No exam took place of the left foot and ankle. Right shoulder was examined that revealed marked tenderness globally over the shoulder. The assessment was left ankle injury with ruling out old fibular avulsion fracture versus a new cuboid avulsion fracture, dysesthesias and hypoesthesia of the left foot of abnormal color changes with rule out of complex regional pain syndrome and right shoulder rotator cuff sprain and ruling out potential of internal derangement. Petitioner was to remain off of work.

On October 1, 2014, Petitioner underwent an MRI of the left ankle. (Px-2) The impression was fibers of the anterior talofibular ligament appeared indistinct which may be a result of prior sprain or partial tear with no abnormal marrow edema to suggest fracture. No other significant abnormalities noted.

On October 4, 2014, a telephone conversation occurred between Dr. Gurtler and Petitioner concerning Petitioner's complaints of dropping a jar of peanut butter. (Px-2) Dr. Gurtler recorded that Petitioner likely suffered from RSD. Dr. Gurtler recommended Petitioner see the specialist in Chicago as soon as possible.

On October 23, 2014, Petitioner saw Dr. Gurtler for her right shoulder injury. (Px-2) The physical exam of Petitioner's elbow noted a scar consistent with a significant blow. Her right shoulder had abduction of 30 degrees and elevation of 40 degrees. Dr. Gurtler review the MRI which showed no convincing rotator cuff tear but some superior labral tears and a bright collection in the anterior superior labrum measuring 12 x 8 x. 10 mm

consistent with a paralabral cyst. Dr. Gurtler felt Petitioner's pain was out of proportion in the left lower extremity consistent with RSD. Dr. Gurtler observed Petitioner's arm was a darker color compared to the other arm and was suspicious of complex regional pain syndrome in her right upper extremity. Dr. Gurtler suggested Petitioner see a specialist for complex regional pain of her shoulder and further evaluation when she is finished.

On November 14, 2014, Petitioner presented to Dr. Grambart. (Px-2) Petitioner's MRI was reviewed which showed an avulsion and fracture with adhesive sides off to the tip of the lateral malleolus. On exam, it was hard to assess what the ankle ligaments were doing given Petitioner's pain level. Petitioner was to continue with work restrictions. Recommendation made for a sedation manipulation of the ankle to see what the ligaments looked like and to see if they were attached to that piece. Petitioner was adamant about having surgery to remove that. Dr. Grambart did not recommend anything until Petitioner saw a pain specialist.

On November 21, 2014, Petitioner returned to Dr. Cohen. (Px-2) He continued her TTD, refilled her Norco with a follow up to be determined after her pain management.

On December 11, 2014, Petitioner was seen by Dr. Lubenow. (Px-3) On exam, Dr. Lubenow indicated the left lower extremity did show edema, temperature changes, erythema, shiny skin, and severe allodynia when compared to the right lower extremity. In addition, Petitioner had significantly reduced range of motion of the left ankle with plantar flexion and dorsal flexion. Examination of the right shoulder showed edema and significant allodynia along the lateral aspect when compared to the left upper extremity. It did not show significant temperature changes. The diagnosis was CRPS of the left lower extremity with suspected peroneal neuropathic pain component and right upper extremity brachioplexopathy with a right shoulder brachial plexopathy with a right shoulder labral tear. Dr. Lubenow stated he would perform a sweat testing at his office that day. EMG was ordered. Petitioner scheduled for a series of lumbar sympathetic blocks to aggressively treat the left lower extremity CRPS.

On December 11, 2014, Petitioner underwent a sweat response test. (Px-3) Hand written notes indicated that there is abnormal increase of sweat in the left foot.

Petitioner presented to Carle Foundation Hospital ER on December 14, 2014 with complaints of right shoulder pain. (Px-2) Petitioner denied any injury but stated she had discomfort with moving her arm. Petitioner was diagnosed with right shoulder pain. Petitioner had limited range of motion by pain but neuro and vascular were intact. The physician found Petitioner had tenderness and pain with minimal palpation which were out of proportion to exam.

On December 17, 2014, Petitioner called into Dr. Gurtler's office. (Px-2) Petitioner relayed that Dr. Lubenow did not believe she was suffering from CRPS in her right shoulder but recommended someone see her who only dealt with shoulder issues and was going to refer Petitioner to a shoulder "super" specialist.

On January 21, 2015, an EMG was performed of the right upper and left lower extremities that was essentially normal. (Px-2)

On January 26, 2015, Petitioner presented to Dr. Christopher Nelson of Carle Department of Family Medicine. (Px-2) Petitioner discussed her recent EMG test. The EMG was unremarkable. The left ankle/foot pain was returning back to baseline. Petitioner to continue to follow up with pain specialist in podiatry. Petitioner was kept off work.

On February 16, 2015, Petitioner followed up with Dr. Nelson. (Px-2) It was noted Petitioner had a nuclear bone scan which was normal. Petitioner was kept off work.

On April 21, 2015, June 25, 2015 and October 1, 2015, Petitioner had a series of a total of three platelet rich plasma injection of her left lower extremity. (Px-2)

On October 12, 2015, Petitioner underwent a left lumbar sympathetic nerve block at L2 and L3. (Px-3) The post-operative diagnosis was CRPS of the left lower extremity and right upper extremity.

On October 12, 2015, Petitioner presented to Dr. Romeo in a wheel chair with left walking boot. (Px-4) Petitioner reported being unable to do any activity with the right shoulder. Petitioner wears a sling most of the time and was wearing one during the visit. On exam, Petitioner extremely distressed with any movement of shoulders. Unable to tolerate examination. Significant pain with any palpation about the shoulder. Dr. Romeo suggested no surgery at that time. Dr. Romeo recommended Petitioner follow up with Dr. Lubenow to attempt to control her pain. Dr. Romeo stated he would agree to see Petitioner after she finished with her pain management.

On October 16, 2015, Petitioner presented to Carle ER after an incident with her husband. (Px-2) Petitioner presented with right shoulder pain and some chronic shoulder problems. Petitioner stated her husband pushed her over and she fell with all of her weight on her right shoulder. Petitioner was standing with the wall behind her and she noted this aggravated her pain.

On December 18, 2015 Petitioner saw Dr. Nelson as a hospital follow up with complaints that the nerve blocks were not managing her LLE pain. (Px-2) Dr. Nelson opined the nero symptoms were causally related treatment from Petitioners work related injuries and deferred to pain management at Rush for CRPS decisions.

On January 14, 2016, Petitioner presented to Dr. Lubenow for right shoulder pain and left leg pain. (Px-3) Petitioner rated her leg pain as a 6-7/10 and right shoulder pain as a 7/10. Petitioner has not had significant relief since her injections. On exam, Petitioner still had right facial droop after stellate ganglion block with variable degree of dysarthria that changes during the 30 minute examination. Petitioner was diagnosed with CRPS of the lower extremity and right upper extremity with avulsion fracture of the ankle and anxiety disorder. Petitioner provided with prescriptions. It was noted there was no medical reason for the Horner's syndrome post stellate ganglion block. Petitioner instructed to meet with Dr. Grambart to determine whether there is an orthopedic intervention for her foot. Also recommended Petitioner see an orthopedic surgeon for her right upper extremity. Petitioner's treatment of her right lower extremity CRPS was complete at this time and will wait after orthopedic procedure to re-evaluate for additional treatment.

On January 19, 2016, Petitioner saw Dr. Nelson after a syncopal episode two days prior. (Px-2) Petitioner reports she was under increased stressors at home and she felt this caused her "Horner's syndrome" symptoms to flare.

On January 25, 2016 Petitioner saw Ms. Lisa Moment, N.P., for left wrist pain after reporting she was walking down some steps and slipped and caught herself with her left hand and her left hand went under her and she heard a snap. (Px-2) Ms. Moment noted there were safety issues at home.

On February 3, 2016, Petitioner presented to Carle ER with history of Menier disease and it was noted she had difficulty with speech and a flare-up of her Horner's syndrome. (Px-2) The ER physician, Dr. Khosrowshahi, did not believe the facial weakness was related to Petitioner's stellate ganglion block, but felt Petitioner was obviously malingering. Dr. Khosrowshahi did not find Petitioner had Bell's palsy.

On February 5, 2016, Petitioner presented to Dr. Gurtler. (Px-2) Dr. Gurtler told Petitioner he believed her situation was too complex for him and he was not comfortable treating her.

On February 8, 2016, Petitioner saw Dr. Nelson who indicated Petitioner had a diagnosis of CRPS, but he could not exclude psychogenic etiology related to her facial issues. (Px-2)

On February 9, 2016, Petitioner presented to Dr. Aaronson who did not feel Petitioner had Horner's syndrome or any persisting symptoms in relation to her stellate block. (Px-2) On exam, Petitioner's gait and station were normal. Toe and heal standing were normal. Dr. Aaronson believed there was some functional overlay.

On February 26, 2016, Petitioner presented to Dr. Grambart. (Px-2) Dr. Grambart examined Petitioner's ankle and felt his examination was consistent with CRPS. No significant skin change noted. He then ordered Petitioner have a new MRI, kept her off work and suggested she may need arthroscopy on her ankle.

On May 31, 2016, Petitioner returned to Dr. Grambart and was still complaining about left ankle pain and was noted she was still using her boot. (Px-2) Dr. Grambart planned on removing the fracture fragment at the tip of the fibula and possibly removing the nerve.

On June 16, 2016, Petitioner had an excision of bone fragment lateral malleolus with advancement and repair with reattachment of the anterior talofibular performed by Dr. Grambart. (Px-2)

On June 24, 2016, Petitioner returned to Erica J. Shroeyer N.P, with Dr. Grambart's office. It was noted she was non-weight bearing and Petitioner was to return to her pain specialist.

On July 1, 2016, Petitioner returned to Erica J. Shroeyer N.P. (Px-2) Petitioner continued to be non-weight bearing with a splint. Petitioner was still unable to return to the pain center.

On July 8, 2016, Petitioner returned to Erica J. Shroeyer N.P. (Px-2) Petitioner has been unable to follow up with her pain specialist. It was noted there were no signs of a CRPS flair up. Petitioner was to be transitioned to a walking boot in two weeks. Petitioner was, encouraged to follow up with her pain specialist.

On July 22, 2016, Petitioner returned to Erica J. Shroeyer N.P. (Px-2) Petitioner returned with 4/10 pain complaints and still unable to return to the pain specialist. It was noted Dr. Grambart attempted to contact workers' comp department to approve an appointment with a pain specialist.

On August 8, 2016, Petitioner returned to Dr. Grambart. (Px-2) Petitioner had 7/10 pain complaints. Dr. Grambart put her in a walking boot. He noted he made multiple efforts to try to get her workers' compensation to approve her seeing Dr. Lubenow but he thought they had refused even though it was medically necessary.

On September 1, 2016, Petitioner returned to Erica J. Shroeyer N.P. (Px-2) Petitioner had 8/10 pain complaints. There was further discussion of the importance of seeing a pain specialist and that Petitioner attempted to get an appointment with Dr. Lubenow.

October 14, 2016, Petitioner saw Casey Buchanan, ATC. (Px-2) Petitioner had pain of aching, burning, radiating pain with continued hypersensitivity along her superficial peroneal nerve distribution. It was noted Petitioner had quite a bit of extension deformity of her toes. From a muscle standpoint he rated her at 3/5 with plantarflexion, dorsiflexion of the ankle, inversion and eversion of the foot. Petitioner was ordered to continue with her boot.

October 26, 2016, Petitioner returned to Shannon Holthaus, N.P. with Dr. Grambart's office. (Px-2) Petitioner complained of an aggravation of her injury on October 15, 2016 after trying to get out of her boot. Petitioner was concerned with a new injury and was unable to flex the ankle or foot.

On January 5, 2017, Petitioner consulted with Dr. Zimmerman. (Px-2) Dr. Zimmerman examined Petitioner with a linear probe of the peroneal tendons. It was noted the tendons were very small in their structure and stature as a result of disuse athrophy. Dr. Zimmerman thought there may be a tear present but wanted to try a newer higher definition ultrasound to confirm his diagnosis. He then recommended possible surgical intervention on the left ankle to be performed by Dr. Grambart and peripheral nerve blocks to help manage Petitioner's pain.

On January 9, 2017, Petitioner saw Dr. Grambart who scheduled Petitioner for a follow-up ultrasound on February 9, 2017 and tentatively set for possible tendon repair. (Px-2) It was mentioned that Petitioner was at an increased risk due to her CRPS. Dr. Grambart stated Petitioner's work status was guarded at that time.

On March 13, 2017, Petitioner saw Dr. Grambart who continued Petitioner use of a boot on as needed basis. (Px-2) He again suggested a pain specialist and a peripheral nerve specialist.

On May 15, 2017, Petitioner saw Dr. Grambart. (Px-2) The ultra sound looked okay but there was a question of some nerve irritation.

A note from Dr. Grambart dated July 7, 2017 supplemented into evidence confirmed Petitioner was off work currently for her injury and was not released to return to work at any time.

Dr. Holmes IME report

Dr. Holmes performed an IME on January 28, 2015. (Rx-4) Dr. Holmes opined Petitioner did not have complex regional pain syndrome. Dr. Holmes indicated there may be some neurologic component to her pain but based on Petitioner's verbal report of a normal EMG, his examination, and by Petitioner's history, he did not believe she had CRPS. Dr. Holmes stated that given Petitioner's history of non-weight bearing, and unable to tolerate much of anything on her foot because of increased sensitivity, one would anticipate that by virtue of that history, there should be some disuse atrophy with regard to her foot which he did not detect.

Based on his review of the MRI and radiographs, Dr. Holmes opined Petitioner did not sustain any injury to the fibula with respect to the fragment that was noted in the initial x-ray. (Rx-4) Photographs taken earlier in June of both feet appeared essentially the same mass and tone. There was no increased swelling between the right and left feet.

Dr. Holmes opined the onset of the shoulder injury and ankle injury were related to the July 21, 2014 accident. (Rx-4) However, Dr. Holmes did not think the objective data correlated with Petitioner's subjective complaints. Dr. Holmes commented that the idea of numbness to one spot over the fibula that was very sensitive did not fit the normal anatomic patterns of the pain fibers in that area and would be inconsistent with the robust nature of Petitioner's muscular skeletal examination taken that day.

Dr. Holmes opined he could not find any objective reason Petitioner would require an examination under anesthesia. (Rx-4) The MRI scan did not suggest any significant ligamentous injury nor any boney injury or instability of the ankle. The MRI also did not confirm the presence of any fusion of the ankle. Dr. Holmes opined there was no need to remove the bone fragment as it related to Petitioner's injury as there was no objective evidence the bone fragment was dislodged, aggravated or injured further as a result of the injury.

Dr. Holmes indicated Petitioner could continue with some of the facets of upper pain management in terms of working out systems to handle her pain. (Rx-4) Petitioner reported improvement with the previous block which would be an avenue for exploration.

From an orthopedic standpoint, Dr. Holmes did not believe Petitioner had any restrictions and did not sustain any life altering injuries or sustained any muscular skeletal trauma of significance to her ankle. (Rx-4) Dr. Holmes placed Petitioner at MMI from an orthopedic standpoint with regard to her foot and ankle injury. Dr. Holmes recommended a second set of eyes concerning the pain syndrome. (Rx-4)

Dr. Boutwell's IME report

On April 24, 2015, Petitioner presented to Dr. Boutwell for an IME. (Rx-6) Dr. Boutwell's IME addressed Petitioner's pain complaints to both her right shoulder and to her left ankle. Dr. Boutwell opined Petitioner did not meet any criteria for the diagnosis of complex regional pain syndrome of the right upper extremity. However, there was a questionable diagnosis of complex regional pain syndrome for the left ankle. It was noted there was some significant color changes in the left foot that could be objectively appreciated. There was also some discrepancy in temperature of the left foot in comparison to the right foot. There was no significant atrophy appreciated which raised some questions regarding the true diagnosis of chronic regional pain syndrome.

Concerning the right shoulder, there was a potential surgical pathology that exists for the right shoulder with a potential diagnosis of brachial plexopathy type injury. (Rx-6) There was also question of adhesive capsulitis/frozen shoulder.

Dr. Boutwell recommended a second sympathetic nerve block for the left foot. (Rx-6) Should that repeat nerve block confirm some significant improvement, Petitioner could continue in that direction of additional nerve blocks. Potential surgical evaluation may be a benefit only if the sympathetic nerve blocks were explored. If Petitioner responded well to the nerve blocks, surgery may not be necessary. The cuboid fracture may be an old injury and simply an incidental finding.

In summary, Dr. Boutwell recommended an evaluation by a board certified orthopedic shoulder specialist and recommended one to four sympathetic nerve blocks to rule in or rule out complex regional pain syndrome. (Rx-6) Recommendation for a specific left foot and ankle re-evaluation can only be considered after the nerve blocks.

Dr. Boutwell opined Petitioner was precluded from returning to work in any sustainable capacity. (Rx-6) Pending Petitioner's response to treatment, exclusive use of the left upper extremity and/or use of the right arm between waist to shoulder level should remain a possibility. Petitioner's use of a walker boot and scooter would allow limited ability to both commute to work and participate in day to day work activities.

Dr. Boutwell did not believe Petitioner was yet at MMI. (Rx-6) Dr. Boutwell believed it was premature to anticipate MMI given the complexity of the two injuries and likelihood of responding to therapy pending the true understanding of the underlying pathology.

Dr. Rotman's IME Report

Dr. Rotman performed an IME on May 9, 2016. (Rx-2) Dr. Rotman found there was no evidence of RSD in Petitioner's right upper extremity. Dr. Rotman opined Petitioner may have a few small paralabral cysts in her

shoulder which may be associated with some minor degenerative lesions in her labrum that pre-existed the injury of July 31, 2014 which may be related more to her sporting activities prior to that date. There was no evidence of frozen shoulder. Dr. Rotman noted there was no atrophy at all in Petitioner's right upper extremities suggesting normal right upper extremity function.

Dr. Rotman noted Petitioner had a multitude of non-organic responses or obviously give way weakness throughout the exam suggesting her subjective complaints were not at all reliable. (Rx-2) Dr. Rotman also addressed Petitioner's right ankle and noted the bone scan showed no evidence of injury to the right ankle. Dr. Rotman stated if Petitioner had any significant sprain or any type of fracture, her bone scan would have been hot for at least a year. There was also no evidence of a superficial peroneal nerve injury. Dr. Rotman noted Petitioner's EMGs in her right upper extremity as well as her left lower extremity were normal despite Petitioner's complaints of numbness and tingling on that days exam and prior exams.

Dr. Rotman found most of Petitioner's treatment to be unnecessary considering the lack of objective findings for an injury. (Rx-2) Dr. Rotman opined Petitioner had been over medicated and there was no reason for narcotic use.

Most importantly, Dr. Rotman found there was no reason objectively for Petitioner to be off of work. (Rx-2) Dr. Rotman stated if Petitioner had frozen shoulder for almost two years, she would have had significant atrophy about her shoulder. Instead, Petitioner actually had more muscle mass about the right shoulder than the left.

Dr. Rotman stated Petitioner presented with an AFO type of brace on the left foot. (Rx-2) Dr. Rotman did not examine Petitioner's left foot but stated his opinions are based on review of Petitioner's records. Dr. Rotman opined Petitioner's care should have been concluded shortly after the work incident. Dr. Rotman stated it was clear Petitioner had issues with symptom magnification not only throughout the course of her treatment but also during his examination of her. As a result of Petitioner's extraordinary subjective complaints, her medical treatment had been prolonged with most of that being unnecessary. Dr. Rotman opined Petitioner required no further treatment for her right upper extremity as it relates to the July 31, 2014 incident. Also, Dr. Rotman opined no further treatment would be required for the lower extremity based on review of the objective findings as well as the multitude of records supplied.

Dr. Rotman placed Petitioner at MMI for a minimal left ankle strain and right arm contusion on July 31, 2014. (Rx-2) Petitioner could return to work without restrictions. Dr. Rotman opined Petitioner required no medications as a result of the accident of July 31, 2014. Dr. Rotman noted Petitioner did have evidence of Raynaud's phenomenon of the right upper extremity involving the tips of her fingers based on the photographs reviewed but this was not due to a work injury. Dr. Rotman opined this condition generally necessitates a rheumatologic workup which should be done through her private health insurance. Raynaud's phenomenon has nothing to do with dystrophy or chronic regional pain syndrome but may be associated with other conditions that have generally rheumatologic such as lupus or other connective tissue diseases.

Dr. Grambart deposition

Dr. Grambart first saw Petitioner on September 4, 2014. (Px-5, T.7) On exam, Petitioner did have sensation that appeared a little bit hypersensitive along the superficial peroneal nerve distribution, which he believed was complex regional pain syndrome (CRPS). (Px-5, T.8) Petitioner also had some bruising and some swelling. Petitioner's bruising and swelling was consistent with the mechanism of injury of falling and twisting her ankle.

The left foot x-ray showed a small evulsion fracture off the lateral cuboid which is the outside part of the bone in the foot. (Px-5, T.9) Dr. Grambart was not a pain specialist, but indicated CRPS is hypersensitivity or trauma to the nerve wherein a patient will typically allodynia, which is pain out of proportion. Also, limited range of motion and foot will change colors. The color will go from a red color to a blue color. There may be an association with sweating or dryness. Trauma or crush injuries are causes of CRPS.

Dr. Grambart suspected Petitioner had CRPS due to the hypersensitivity. (Px-5, T.10) Dr. Grambart recommended an MRI.

Dr. Grambart reviewed Petitioner's MRI which showed the interior talofibular ligament appeared indistinct, so it was questionable for an injury at that point. (Px-5, T.11) There was no abnormal neural edema to suggest any acute fractures and there was no other abnormalities.

At the November 14, 2014 visit, Petitioner was still having hypersensitivity and exhibited guarding with exam. (Px-5, T.12) The exam would be consistent with a diagnosis of CRPS. Petitioner was to maintain her current work restrictions. Dr. Grambart did recommend a sedation manipulation to assess the ligaments. At that point, Petitioner really wanted surgery to remove the fractured fragment piece, but Dr. Grambart told her to hold off.

On January 22, 2015, Petitioner underwent the sedation procedure. (Px-5, T.14) Petitioner's ligaments appeared to be stable on the bone fracture piece. An injection into the ankle joint was performed as well to see if Petitioner had any impingement in the ankle or soft tissue. Dr. Grambart did not see any disruption of the ligaments with the injection. Petitioner still reported having the same pain she had pre-operatively, which told him there was probably no ankle joint or at least anterior ankle joint impingement or any problems which led him to believe it was more of a nerve pain.

Dr. Grambart performed platelet rich plasma injections to try to stimulate some healing around the nerve. (Px-5, T.15) The first injection was on April 21, 2015 and the second one was on June 25, 2015. (Px-5, T.16) Petitioner had a third platelet rich plasma injection on October 1, 2015. (T.17) Petitioner reported that at one point the injections may have helped a little bit but Dr. Grambart did not believe it made a huge improvement.

Dr. Grambart next saw Petitioner on February 26, 2016. (Px-5, T.17) Petitioner expressed concern about the small chip fracture off the cuboid. (Px-5, T.18) Based on examination, Dr. Grambart believed it was basically the same compared to her last visit wherein Petitioner still had nerve pain along with tenderness long the front outside part of the ankle joint line. Dr. Grambart did not notice any skin changes. Surgical repair was discussed. Dr. Grambart recommended a repeat MRI. (Px-5, T.19) Petitioner was kept off work.

Petitioner underwent a second MRI on April 19, 2016. (Px-5, T.19) Nothing had changed. Petitioner still had the fragment at the tip of the lateral malleolus that appeared to be un-united. Petitioner's calcaneal fibular ligament was intact and she had some mild tendinosis of one of the tendons on the outside which was basically a little bit of scar tissue.

Petitioner next presented on May 31, 2016 wherein there was discussion about taking out the fractured fragment. (Px-5, T.20) Petitioner also asked about taking out the nerve along the outside part of the foot and ankle where she was having the nerve type pain.

Dr. Grambart commented the sural nerve, which is the nerve that runs on the outside part of the ankle, still had tenderness on the tip of the fibula. (Px-5, T. 21) Petitioner had some atrophy of the calf muscles, which is a thinning or a muscle wearing of the calf muscles and her toes were starting to develop extension deformities

where they were starting to pull up. Dr. Grambart stated atrophy in the calf is when a patient is not moving their calf up and down.

With the toes, Dr. Grambart noted they were starting to extend up more where she was almost developing a claw toe or an extension deformity and she was definitely getting some muscle imbalance with that. (Px-5, T.22) Those symptoms would not be consistent with ankle instability, as he sees patients with ankle instability that don't have muscle atrophy or the claw toes. He believed it was potentially more from a nerve type injury.

On June 15, 2016, Dr. Grambart performed surgery. (Px-5, T. 23) The surgery went well. Dr. Grambart found the bone piece itself coming off the tip of the fibula. Dr. Grambart did have to repair and advance Petitioner's ligament that was attached to that piece. He also removed a small bone fragment off the anterior process of the calcaneus. The bone fragment that was found was likely caused by a twisting inversion type of injury. Dr. Grambart opined Petitioner's type of injury would explain the continued ankle instability and pain complaints.

Dr. Grambart saw Petitioner on July 8, 2016. (Px-5, T.28) Petitioner had gone to the ER on July 6 or 7, 2016 and had a CT scan to rule out any type of pulmonary embolism which came back negative. Petitioner was next seen on August 12, 2016. Petitioner was still in a walking cast and described 7 out of 10 pain. Petitioner described a nerve burning type of pain. There were no signs of infection. On exam of the left lower extremity, Dr. Grambart noted there was still hypersensitivity along the superficial peroneal nerve. The plan was to convert her to a walking boot after the weekend so she could start moving her foot up and down

Petitioner's current diagnosis was status post-ankle ligament repair with fracture fragment removal as well as CRPS. (Px-5, T.29) Dr. Grambart opined Petitioner still had CRPS as her pain specialist, Dr. Lubenow, had diagnosed her with that as well as Petitioner's clinical symptoms of hypersensitivity along the nerve, along with some of the changes seen in the positioning of the foot and Petitioner's lack of moving it. (Px-5, T.29-30)

Dr. Grambart's prognosis at this point was still too early to tell. (Px-5, T.30) Ligament repair generally takes about six months to recover from. Dr. Grambart's plan was to have Petitioner continue moving around on her foot.

Dr. Grambart opined Petitioner's accident could have either aggravated or caused the bone fragment noted in the June 15, 2016 operative report. (Px-5, T.32) The basis of Dr. Grambart's opinion was that Petitioner was not having any problems with the bone fragment prior to her accident and subsequently had the pain since then. Dr. Grambart opined Petitioner's CRPS was related to her accident.

Dr. Grambart opined Petitioner's CRPS was related on the basis she wasn't having any pain to the ankle prior to this. (Px-5, T.33) Dr. Grambart recommended Petitioner to remain off work.

Dr. Grambart believed the bone fragment was from a prior injury that pre-dated July 31, 2014. (Px-5, T.34) Petitioner wasn't having symptoms prior to the twisting mechanism and with the inversion injury, Petitioner could have re-aggravated or caused pain in that area. It was possible a patient could have had a pre-existing injury that was symptomatic but did not seek treatment for it. The October 1, 2014 MRI did not reveal any acute trauma or injuries.

All of the MRI findings could have pre-existed the injury. (Px-5, T.35) The stress exam revealed Petitioner's ankle ligaments were intact. The October 1, 2014 MRI showed an indistinct ligament indicating a prior sprain or partial tear. The April 19, 2016 MRI showed the ligament appeared intact but was attached to the fracture fragment.

The indistinct ligament shown on the first MRI could indicate a prior trauma. (Px-5, T.36) The fracture fragment pre-existed the July 31, 2014 accident but Dr. Grambart was unable to determine the ligament injury as it was hard to assess without a prior MRI.

Dr. Grambart is not sure how CRPS and EMGs correlate. (T.37) Dr. Grambart did not know if his opinion would be a diagnosis of CRPS if Petitioner's EMG was normal. If the bone scan showed no evidence of abnormal ankle uptake, Dr. Grambart would not have an opinion on how that affects the CRPS. The only thing on the diagnostic films that provided objective evidence outside of Petitioner's subjective complaints to support surgery was the un-united fracture fragment at the tip of the fibula.

Petitioner's continued treatment has been based on her subjective complaints that she has been tender to palpation and she had hypersensitivity of the nerve. (T.38) There is no way to objectively prove Petitioner's pain symptoms.

Wearing a walking cast can cause atrophy. (T.39) If Petitioner had been in a boot and advised she was non-weight bearing, it would surprise Dr. Grambart if Petitioner had no atrophy in the left ankle or foot as he would expect some atrophy. If Petitioner's left ankle or foot had no atrophy, it does indicate she has been using the foot, at least moving it up and down.

Dr. Grambart would expect Petitioner would have pain with the CRPS trying to move her foot up and down. (Px-5, T.40) With Petitioner's severe pain complaints, he would expect some type of atrophy given her described pain level.

During the manipulation in January 2015, Petitioner's ligaments were stable and were not torn. (Px-5, T.41) There was no ankle impingement. Dr. Grambart was of the opinion Petitioner had a nerve problem. It was hard to get a true finding as to whether the bone fragment was the cause of her pain as Petitioner was so sensitive on the nerve.

At the time of the June 2016 surgery, Petitioner was still having nerve pain. (Px-5, T.42) Dr. Grambart believed it was too soon to determine whether the bone fragment or the nerve was the cause of Petitioner's pain. Dr. Grambart did not recall any symptom exaggeration as Petitioner was pretty consistent throughout.

With Petitioner's bone fragment, as long as it was asymptomatic, people could walk and function fairly normal. (T.43) Dr. Grambart had not seen the record of February 2016 which showed Petitioner walked with a normal gait. Dr. Grambart would not expect her to walk with a normal gait at that time.

If a person has a normal gait even though they have a bone fragment in their foot, it suggests to Dr. Grambart that they are asymptomatic at that area. (Px-5, T.44) With the CRPS, he would expect Petitioner to have an abnormal gait.

If a person was asymptomatic, he would not have performed surgery as long as the patient was able to do everything they wanted to do. (Px-5, T.45) Dr. Grambart did not recall reviewing any records that suggested Petitioner had subjective complaints out of proportion of her objective exams. Dr. Grambart did not specifically remember if he looked at any of any of Dr. Lubenow's records or what they said exactly. Dr. Grambart would defer to Dr. Lubenow when it came to the CRPS diagnosis.

The only evidence of Dr. Grambart diagnosing Petitioner was CRPS is based on her subjective complaints of hypersensitivity when he pushed on the nerve. (Px-5, T.46)

With a plantar flexion inversion injury or a twisting mechanism, the ligaments will be stressed and if the ligament is attached to the bone fragment, it could aggravate it. (Px-5, T.47) The injury could aggravate it to a point where surgical intervention is reasonable and necessary. Dr. Grambart testified a patient could walk with a fractured bone piece and have no problems.

Dr. Grambart did not actually diagnose Petitioner with CRPS but thought she had it. (Px-5, T.49)

If Petitioner had a normal gait pattern, he would say she was probably asymptomatic. (Px-5, T.50) The bruising and swelling Dr. Grambart saw on the initial exam did go away.

In reviewing the follow up visit from November 14, 2014, Dr. Grambart did not note any swelling or bruising. (Px-5, T.51)

Deposition of Dr. Romeo

Dr. Romeo first saw Petitioner on October 12, 2015. (Px-4, T.7) Petitioner reported an injury on July 31, 2014 when she fell on pavement while at work. An MRI was obtained that demonstrated a superior labral tear. Petitioner had not had any physical therapy. Petitioner continued to have significant issues with the right shoulder.

Petitioner reported she was unable to do any activity with the right shoulder. (Px-4, T.8) She wore a sling. Dr. Romeo performed a physical examination and Petitioner was unable to tolerate a full examination. She was distressed with any movement of her shoulders. Petitioner able to elevate her arm in a forward direction to approximately 50 degrees in forward elevation. Petitioner able to externally elevate her arm to a neutral position which is essentially a handshake position. Significant pain with any palpation or touching of her shoulder. Petitioner winced with pain and nearly jumped out of her wheelchair. No skin changes overlying the area where she had pictures or discoloration of her fingertips. No sensory changes distally into her fingers. Strength was not able to be tested as well as any provocative examinations due to overall painful exam.

Based on the physical exam and review of the MRI, Dr. Romeo suggested that there is no surgical intervention that would significantly make Petitioner better because her pain was out of proportion to any potential problems with her shoulder. (Px-4, T.10) Dr. Romeo recommended a pain management specialist, Dr. Lubenow, in an attempt to control Petitioner's pain and Dr. Romeo would be happy to see Petitioner after she saw Dr. Lubenow. At that time, Dr. Romeo felt there was no structural problem that would significantly improve the structure or repair of that area with surgery which would in any way improve her overall outcome. The MRI did not answer whether the labral problems were of a traumatic or more of a chronic or degenerative in nature.

The MRI showed a bright collection seen boarding the anterior superior labrum and findings consistent with the paralabral cyst. (Px-4, T.11) A cyst develops in this area when there is often a tear or fraying of the labrum and fluid from the joint mixed into the labral tissue forming a collection of fluid which is known as a cyst. There was a second small posterior superior labral tear and a tiny paralabral cyst. The actual type of cyst could not be accorded to either traumatic or degenerative in a 46 year old lady. Either possibility could be the cause of Petitioner's problem.

The mechanism of injury where Ms. Howard fell with the full weight of her body pushing her arm back and onto her elbow, landing on her elbow and pushing her arm back is the kind of injury that could cause either a chronic or traumatic injury to the labrum. (Px-4, T.13) The most common injury to the shoulder when a person has a fall on an outstretched hand which is a fall onto the forearm and elbow driving an arm in an upward

direction as a labral tear or rotator cuff tear. The history of a fall on an outstretched arm without a prior history of any prior shoulder problems is the evidence to suggest Petitioner's fall was the cause of her problem. Dr. Romeo opined the fall rendered the degenerative conditions symptomatic and it may have caused some acute changes. (Px-4, T.14)

There was a neurologic component to Petitioner's symptoms when she saw Dr. Romeo on October 12, 2015 which could be a chronic regional pain syndrome or a brachial plexopathy which Dr. Lubenow thought was more consistent with the findings he saw. (Px-4, T.15) The brachial plexus is the group of nerves that come from the neck and then form the plexus or grouping of nerves that then go out into the shoulder and includes the nerves that go into the area around the shoulder and into the arm, forearm and hand for which Petitioner was having discomfort, numbness and tingling.

The pain Petitioner was experiencing was much more consistent with either chronic regional pain syndrome or a brachial plexopathy which are conditions not treated by surgical management. (Px-4, T.16) The exam Dr. Romeo performed could not clearly identify that the labral tear was the source of the majority of Petitioner's pain. Dr. Romeo could not recommend any surgery based on his one evaluation because the majority of Petitioner's symptoms were neurologic in nature and he had nothing to offer. If Petitioner has an orthopedic problem such as a labral tear that is causing her symptoms that can be treated with orthopedic surgery, then Dr. Romeo would be happy to evaluate her again.

Dr. Romeo did not make any comments about symptom magnification. (Px-4, T.18) Patients who truly have brachial plexopathy or severe chronic regional pain syndrome are patients that have the worst pain they have ever experienced in their life. Dr. Romeo assumed her condition was neurologically-mediated which is tremendously painful.

Dr. Romeo's exam of Petitioner took place on October 12, 2015 which is approximately 15 months after her claimed accident. (Px-4, T.20)

No one had provided a good clinical exam until Petitioner saw Dr. Romeo on October 12, 2015 and he was not able to get a good clinical exam as Petitioner's symptoms were related primarily to pain of neurologic etiology. (Px-4, T.21)

Anywhere Dr. Romeo touched Petitioner's shoulder was severely painful for her. (Px-4, T.22) Even a light touch would have been painful. Even though a light touch caused Petitioner pain, she was still able to wear a sling.

Petitioner's sling was worn around her forearm, elbow and hand area, he was trying to exam her from the mid-arm up to her neck and the strap from the sling goes around the other side of her neck. (Px-4, T.23) The sling really was not putting any direct contact in this area around her shoulder that he was trying to exam.

Dr. Romeo was not aware of the timeline of how long Petitioner had been unable to use her right arm. (Px-4, T.24) Dr. Romeo did not know the intensity and the frequency and severity of her symptoms over the 15 months from the date of accident until he saw her. If a patient describes they are not using their arm for a period of time and they are wearing a sling, Dr. Romeo testified the expected answer is that atrophy or wasting of the arm should be seen but he rarely if ever sees that unless there is a complete neurologic injury where the nerve has been severed.

What Dr. Romeo can see sometimes is that there could be some thinning out of the muscle and there could be some skin changes. (Px-4, T.25) Dr. Romeo mentioned in his note that Petitioner brought pictures of

discoloration of her skin of her fingertips although he saw nothing like that during his examination. Dr. Romeo did not see any atrophy. Atrophy means to not build or not build up or breakdown which means that muscles normally have a shape to them and when they are either not being used for a long time or when the nerve to that muscle is absent or not functioning, the muscle disappears or goes away or breaks down and so it takes the shape of a sunken-in or decreased amount of material underneath the skin in a specific area.

Petitioner did have some finding consistent with frozen shoulder in terms of the range of motion that she had but with the severity of her neurologic symptoms that was a separate problem than a true frozen shoulder. (Px-4, T.27)

Dr. Romeo would leave the diagnosis of chronic regional pain syndrome to a specialist. (Px-4, T.29)

Petitioner came to him with the diagnosis of chronic regional pain syndrome based on the evaluation she had with a doctor in St. Louis and that was what Dr. Romeo was reporting. (T.30) Dr. Romeo did not review the report from the doctor in St. Louis.

Dr. Romeo did not perform any specific testing such as a sweat test, measuring of the arms, or determine if there was any discoloration or checking of skin temperature of Ms. Howard to assess the diagnosis of chronic regional pain syndrome. (T.31)

Dr. Romeo did not perform any distraction test to confirm the validity of Petitioner's complaints. (Px-4, T.32) It was not possible to distract Petitioner because her pain was so significant and that is what he mentioned when Petitioner winced with pain and nearly jumped out of her wheelchair that any palpation around her shoulder resulted in pain.

The MRI findings does not necessarily indicate by itself that a person is symptomatic. (Px-4, T.33) A person could have the labrum tear noted on the MRI prior to a trauma and it could be asymptomatic. Dr. Romeo was not provided a history of Petitioner's prior hobbies. Dr. Romeo was also not aware Petitioner was involved in prior activities involving softball, basketball and golf.

Sporting activities such as softball and basketball can cause a labral lesion or tear. (Px-4, T.34) A cyst will normally develop over time. Dr. Romeo is not aware of any studies as to how long it would normally take for a cyst to develop after a labral tear. A cyst could develop in a matter of weeks. There was no requirement Petitioner use a sling. Petitioner was using a sling in an elective manner to try to alleviate her pain. Dr. Romeo did not believe a sling actually provided the relief a patient was looking for other than it sometimes gives them a better sense of security of the arm being by the side but he was not certain that it does much benefit. (T.35)

It is possible the labral lesion or tear that were found were incidental findings. (Px-4, T.39)

Deposition of Dr. Lubenow

Dr. Lubenow first saw Petitioner on December 11, 2014. (Px-3, T.6) Petitioner was seen for complaints of left ankle, left foot and right shoulder pain.

Petitioner presented with symptoms of left ankle constant pain of a varying intensity. (Px-3, T.8) She has periods when this pain felt as if it was a burning match lit under the bottom of the foot and spreads upwards towards the knee. It involved most of the anterior shin where she had an excruciating burning sensation. Petitioner also had chronic, baseline, sharp pain below the knee involving the entire anterior shin and dorsum of the foot, lateral aspect more than medial. Petitioner noticed the development of more coarse, dark hair of the

left lower extremity when compared to the right along with the shiny skin of the left lower extremity and a significant increased sensitivity to any touch of the left lower extremity.

Petitioner had difficulty sleeping at night and often could not have bedsheets overlay her left lower extremity from the knee on down due to significant pain. (Px-3, T.9-10) Petitioner noted discoloration of the left lower extremity with periods of cyanosis and erythema when compared to the right along with edema of the left lower extremity. Petitioner currently able to ambulate with the aid of a boot on the left lower extremity although she favored significantly her lower extremity when compared to the other one and was not able to plantarflex.

Dr. Lubenow performed a physical exam which showed edema of the left lower extremity, temperature changes, erythematous discoloration of the left lower extremity, shiny skin, severe allodynia when compared to the right lower extremity. (Px-3, T.10) Petitioner had significantly reduced range of motion of the left ankle with plantarflexion and dorsiflexion. Petitioner had 4+/5 strength with regard to plantarflexion and dorsiflexion of the left leg when compared to the right. Ambulation was impaired. With the boot off, Petitioner had significant pain and was unable to plantar flex with the left lower extremity. Petitioner had restricted to heal striking of the left lower extremity only and had significantly favored weighed faring with the right lower extremity. With regard to the right upper extremity and shoulder, Petitioner had edema and significant allodynia along the lateral aspect when compared to the left upper extremity. No temperature differences.

Dr. Lubenow reviewed the MRI results of Petitioner's right shoulder and left ankle. (Px-3, T.11) Dr. Lubenow ordered an EMG of the right arm and left leg along with treatment with a series of sympathetic blocks, discontinued gabapentin and started Lyrica.

Sweat test showed left lower extremity demonstrated abnormal finding with increase sweat of the left foot and ankle when compared to the right which was consistent with CRPS and confirmed the presence of a sweat abnormality of the left lower extremity. (Px-3, T.12) Sweat test of the shoulder was normal. There was a slight abnormality of the left arm producing a greater sweat volume than the right so that finding pointed to an increase sweat production of the left side when compared to the right but was similar to equivocal because some different findings with regard to the ending offset.

Dr. Lubenow diagnosed Petitioner complex regional pain syndrome of the left lower extremity with a suspected peroneal neuropathic pain component and a right upper extremity brachial plexopathy with a right shoulder labral tear. (Px-3, T.13) CRPS is a neurological pain condition characterized by an abnormal response of the nervous system to some type of antecedent event. The antecedent event is most commonly some type of trauma such as accidental or a controlled-surgical trauma.

CRPS results in a constellation of certain symptoms and a physical exam finding that includes such things but not necessarily limited to complaints of hypersensitivity with physical exam findings of allodynia; complaints of discoloration with physical exam findings of discoloration; complaints of temperature asymmetry in an extremity that has been injured; complaints of increased sweat production of edema; and finally, the final category is complaints or physical exam findings of decreased active range of motion, weakness or atrophy, change in hair growth, change in nail growth and other trophic changes, like shininess of the skin. (Px-3, T.14) At least half of Dr. Lubenow's practice is taking care of CRPS patients.

The basis of Dr. Lubenow's diagnosis of CRPS of the left lower extremity was that Petitioner had trauma when she slept and had the inversion injury to the left lower extremity. (Px-3, T.15) She then had further ongoing complaints that included complaints of hypersensitivity, complaint of discoloration, complaint of swelling, complaint of shininess of her skin which were her subjective complaints. The physical exam findings were the allodynia, discoloration, complaint of swelling, complaint of shininess of her skin, increased hair growth noted

on the left lower extremity as well as decreased range of motion of the left lower extremity. The sweat test was noted as well. Petitioner had physical exam findings in each of the four categories with regard to the Budapest Criteria.

The Budapest Criteria includes the category of pain which relates to sensory disturbance, second category relates to autonomic disturbance, which his characterized by either temperature asymmetry or discoloration, the third category is the sweat and edema category and the fourth category is the motor/trophic category. (Px-3, T.16) Allodynia is the objective correlate to the subjective complaint of hypersensitivity which is the unusual painful response to a normal tactile stimulation. Dr. Lubenow determines it is objective based on physical examination wherein he would lightly stroke the effected extremity to note whether or not the patient has any manifestation of pain, such as facial grimacing, attempt to pull the extremity away from you or something of that nature.

Dr. Lubenow believed Petitioner had brachial plexopathy of the right shoulder which is an injury to a group of nerve fibers that feed the upper extremity. (Px-3, T.17) Brachial plexopathy can be caused by trauma such as a fall or can be caused by surgery or viral infection.

Dr. Lubenow's assessment was CRPS of the left leg and brachial plexopathy of the right shoulder which both needed to be treated. (Px-3, T.18) CRPS can wax and wane where there are periods of time where it is worse and periods of time when it may be better.

Dr. Lubenow would not agree that CRPS can resolve over time. (Px-3, T.19) It was Dr. Lubenow's experience that by the time a patient's pain reaches the pain clinic environment, more likely than not, patients will have chronic persistent pain probable to some degree that is going to require ongoing treatment. Dr. Lubenow's treatment plan was to carry on a series of lumbar sympathetic blocks of the left lower extremity and then carry on with conservative care for the shoulder.

On October 12, 2015, October 26, 2015 and November 10, 2015, Petitioner had nerve blocks. (Px-3, T.20) Petitioner was admitted overnight because of the first injection due to some possible issues related to bleeding.

Petitioner was seen by Dr. Lubenow on November 11, 2015. (Px-3, T.20) The second injection went well and the third injection was uneventful. (Px-3, T.21) Petitioner returned feeling like she was 50% overall improved with regard to the hypersensitivity complaint and her ability to function. Petitioner reported swelling had improved. Petitioner denied any color changes. Petitioner was having some positive response to the series of sympathetic blocks. The sympathetic blocks are part of the care and treatment of CRPS of the left lower extremity. The blocks are therapeutic and are meant to treat the condition coupled with physical therapy and exercise.

Petitioner's indication she had 50% improvement after the blocks suggested she was responding favorably to a diagnosis of CRPS. (Px-3, T.22) Petitioner's response confirmed his diagnosis.

On December 1, 2015, Petitioner was seen by his partner wherein she had a stellate ganglion block to see if her right upper extremity symptoms would improve to the point where Dr. Romeo would operate on her. (Px-3, T.23) Petitioner's blocks went uneventfully and proceeded with a typical response to the injection. Petitioner was seen for follow up in January 14, 2016.

By the January 14, 2016 visit, Petitioner had a series of six lumbar sympathetic blocks for the left leg. (Px-3, T.24) Petitioner had been out of her wheelchair since Christmas. Petitioner had some nuance of right facial drooping and dysarthria since the stellate ganglion block which was noted one day after the block happened.

Petitioner was feeling better with regard to the left leg. Petitioner was referred to Dr. Merriman who is a psychologist who usually sees patients who have CRPS as part of the initial evaluation and treatment for patients with this condition.

There was discussion of Petitioner having Horner's syndrome where Petitioner had some degree of facial droop where he was not quite sure what the etiology was. (Px-3, T.25) A stellate ganglion block can produce Horner's syndrome.

Petitioner having Horner's syndrome for about four weeks was a little unusual. (Px-3, T.26) There is no medical reason for it. Dr. Lubenow's record reflects that Horner's syndrome can be a result of anxiety. Dr. Lubenow recommended an orthopedic evaluation for treatment of the right upper extremity and recommended she see Dr. Romeo.

Petitioner's left lower extremity noted some improvement and he recommended conservative care. (Px-3, T.27) Dr. Lubenow did not believe Petitioner had a diagnosis of CRPS for the right shoulder.

In review of Dr. Lubenow's March 23, 2016 note, he indicated that with regard to any pain treatment Petitioner was at MMI and she could proceed with whatever surgery Dr. Romeo deemed was medical necessary. (Px-3, T.28) For the left lower extremity, he recommended for her to return two months later after the orthopedic surgery of the right upper extremity to reexamine her left lower extremity. Petitioner might or might not need additional treatment.

Dr. Lubenow has not seen Petitioner since March 23, 2016. (Px-3, T.29)

Given Petitioner's history of CRPS with responsive partial pain improvement but still significant enough pain that Petitioner required medications of OxyContin and Norco, there is further medically necessary treatment that is available to improve Petitioner's pain conditions so that she would not have to take opiate medications and could improve her functional well-being with regarding the left lower extremity. (Px-3, T.30) If Petitioner underwent surgery by Dr. Grambart regarding her left lower extremity, it is possible she could have further aggravated her underlying CRPS condition.

The mechanism of injury described by Petitioner could contribute to the development or aggravate the conditions of which Dr. Lubenow has diagnosed her with respect to her left ankle and right shoulder. (Px-3, T.31)

Dr. Lubenow is part of the panel of 25 physicians who were asked to participate in the International Association for the Study of Pain and met in Budapest in 2003 to refine the diagnostic criteria for CRPS. (Px-3, T.33)

This panel met for two days to discuss the diagnostic criteria for CRPS and came up with a recommendation that patients should have a minimum three symptoms and then two physical exam findings to confirm a diagnosis of CRPS. (Px-3, T.34) They then made the recommendation to the International Association for the Study of Pain by way of some written text book in 2005.

After a randomized control study that was carried out from 2006 to 2008 the results were published in 2010 and confirmed that the Budapest criteria of three symptoms and two physical exam findings was the best combination of sensitivity and specificity to confirm a diagnosis of CRPS. (Px-3, T.35)

Dr. Lubenow did not have an independent recollection as to how long his first exam of Petitioner took place. (Px-3, T.37) The usual trial frame would be about 45 to 50 minutes. Dr. Lubenow could not recall the time of

day he say Ms. Howard at the December 11, 2014 visit. When Petitioner first presented to Dr. Lubenow, she was wearing a boot on the left foot. In response to questioning of how long Petitioner would have worn the boot the day Dr. Lubenow examined her, Dr. Lubenow responded Petitioner would have taken it off during a portion of the physical exam and would have had it off when she had the sweat test.

Petitioner would have had the boot off prior to the sweat test probably for five minutes or longer. (Px-3, T.38) Petitioner would have had the boot on during the history portion of the exam and during the physical exam the boot would have either been taken off by him or by Petitioner. At the conclusion of the visit, Petitioner most likely would have put the boot on or kept it off because the sweat test usually comes shortly after the history and physical exam.

Dr. Lubenow testified that from a subjective standpoint to support the diagnosis of CRPS, he noted she has hypersensitivity, discoloration, swelling and shininess of the skin. (Px-3, T.39) From an objective standpoint, Dr. Lubenow indicated Petitioner had allodynia, the sweat test, discoloration, swelling, decreased range of motion and increased hair growth.

With respect to the first category, the sensory category, Petitioner demonstrated severe allodynia, with regard to the autonomic category Petitioner had discoloration, with regard to the edema and sweat category, Petitioner had each of those present and therefore she had three physical exam findings in the first three categories. (Px-3, T.40) With regard to the motor/trophic category, Petitioner had hair growth difference, she had decreased range of motion differences with regard to the ankle, she had shininess of the skin and so the physical exam finding in each of those four categories as it relates to the Budapest criteria. So even though it only finds two physical exam findings, Petitioner had four.

Allodynia is the objective correlate to the subjective complaint of hyper sensitivity. (Px-3, T.41)

Dr. Lubenow stated that for an experienced pain physician, one can objectify the physical exam finding of allodynia by first demonstrating that patients have some degree of painful response to a simple normal tactile stimulation usually done by lightly stroking the skin and then later on during the examination focusing the attention away from the painful extremity and distracting the patient then the physician applies a similar type of stimulus to the that painful left leg and note whether or not patients have a similar degree of painful response or grimacing like they did initially when they were focusing the physical exam finding on that painful extremity. (Px-3, T.42)

Dr. Lubenow would disagree that the definition of allodynia would be dependent on the subjective response from a patient. (Px-3, T.43) Dr. Lubenow noted Petitioner had discoloration in his own exam finding. Dr. Lubenow's note indicated Petitioner had erythema which is a reddish discoloration of the skin and then continues on with shiny skin.

Dr. Lubenow initially stated in his physical exam findings Petitioner had deformity in her hair growth. (Px-3, T.44) When asked how he was able to make the determination with the hair deformity, Dr. Lubenow stated he stood corrected and the physical exam portion indicated he did not comment one way or another with observing a difference in the hair growth. Dr. Lubenow stated there was decreased range of motion which required some amount of physical touching by him.

Dr. Lubenow then stated he was not actually physically touching the patient when he was measuring the range of motion because he was holding the instrument immediately parallel lining up the two plane of motion that were measuring the arch of motion through. (Px-3, T.45) Dr. Lubenow is not board certified in orthopedic medicine.

Dr. Lubenow testified wearing a boot cannot effect the sweat test. (Px-3, T.57) Dr. Lubenow testified he was measuring temperature. The sweat test is performed by placing a small disc of acetylcholine on a symmetrical area of the body. Acetylcholine is a neuro transmitter that the body has that normally causes the release of sweat by sympathetic nerves. It is a physiologic stress applied to both sides of the body and looking for characteristic response. Generally, you will see a little bit of sweat symmetrically produced in both extremities.

In the CRPS extremity, there is an asymmetrical response with the greater amount of sweat produced than in a contralateral normal extremity. (Px-3, T.58) Whether or not somebody had a boot on for a few minutes before does not have any real relationship with because this is a provocative test that is looking at the amount of sweat produced in response to an acetylcholine challenge. Wearing a boot could affect temperature change.

Dr. Lubenow testified it is not inconsistent for Petitioner to have severe allodynia and have the ability to wear her boot. (Px-3, T.59) Patients with allodynia have most intense pain when they are first putting the boot on but once the boot is on and stable across the skin the pain is less intense. With the boot off, Petitioner had a greater amount of pain and was unable to even let her foot touch the floor. Dr. Lubenow stated Petitioner could not touch the floor but she could touch a boot.

There is no gold standard laboratory or imaging test to establish CRPS. (Px-3, T.60) CRPS generally begins with some degree of traumatic insult. CRPS can resolve on its own.

If Petitioner found to be walking with a regular gait, Dr. Lehman did not believe it would not necessarily call into question whether she had CRPS. (Px-3, T.61) A patient can have mild manifestation of CRPS and walk with a normal gait.

For the Budapest criteria, a patient need only display two out of the four components. (Px-3, T.62) The other diagnosis he considered that could have contributed to Petitioner's complaints were peroneal neuropathy which was the purpose for the EMG.

Petitioner had complex regional pain syndrome I which is when there is no distinct major nerve damage. (Px-3, T.63)

When Dr. Lubenow realized he was mistaken about noticing lack of hair growth in the first examination, it did not change his diagnosis or opinions. (Px-3, T.63) Dr. Lubenow testified Petitioner had more than sufficient physical exam findings in the motor/trophic category to still qualify for having a physical exam finding in that category.

Dr. Rotman Deposition

On May 9, 2016, Dr. Rotman performed an Independent Medical Examination on Laura Howard. (Rx-3, T.7) Petitioner reported she had tears in her biceps, cysts, muscle problems, chronic regional pain syndrome, thoracic outlet syndrome, and a rotator cuff tear which where all related to the shoulder injury. (Rx-3, T.9)

Petitioner complained of numbness and tingling in her entire hand up to her outer shoulder with numbness in her palms and all of her fingers. (Rx-3, T.9) Petitioner complained her fingertips turned white and showed him a photograph. Petitioner did a pain diagram and circled all the way down her right upper extremity. Dr. Rotman diagnosed Petitioner with Raynaud's phenomenon for the digits that turned purple in the fingertips.

Raynaud's phenomenon has nothing to do with the diagnosis of RSD and is a completely different problem. (Rx-3, T.10) Raynaud's is a vascular spasm that could be associated with a rheumatologic disorder like lupus or could be all on its own. Raynaud's disease appears when the vessels clamp down and are generally aggravated by cold or stress and the fingers will turn white and then when the blood flow comes back they turn red. In Petitioner's case, it was a vascular spasm issue and not a result from cold. The Raynaud's phenomenon would have no causal relationship to Petitioner's claimed injury.

Dr. Rotman noted the February 11, 2015 three phase bone scan was one of the best tests to prove RSD as it showed positive findings for dystrophy. (Rx-3, T.13) A bone scan was also a good test to show in injury was a fracture or joint injury will show up even up to a year. Petitioner's bone scans showed no abnormal uptake. The left and right ankles looked completely equal. The shoulders looked completely equal. The hands looked completely equal.

The bone scan was completely normal indicating no evidence of ankle or shoulder injury and no evidence of dystrophy. (Rx-3, T.14) Physical exam revealed no pain from Petitioner's neck. Petitioner had normal muscle mass about her right shoulder and no atrophy. The muscles looked stronger about her right shoulder. The muscles were a little bit bigger on the right than on the left because Petitioner is right handed. The fact Petitioner had more muscles on the right than on the left suggested that she was using the arms pretty well. A person cannot have frozen shoulder without atrophy. A person cannot have dystrophy without atrophy. A person will get atrophy within a month or two of having a frozen shoulder or any type of dystrophy.

Dr. Rotman took measurements and the biceps measured both on the right and left at 37cm which were equal. (Rx-3, T.15) Petitioner's right forearm had 27 cm and on the left was 25.5 on the left which is significant. Petitioner has bigger muscles on the right forearm than the left because she is right handed and using the right hand and arm well or else she would not have that. Petitioner's wrists were measured on the right as 26.5 and on the left was 26 and her hands looked normal. Petitioner's elbows looked normal. Petitioner's elbows looked normal. Petitioner's skin looked normal. Her color looked normal. No wrinkle changes. Petitioner had no findings would have at all been consistent with any type of dystrophy or injury. Dr. Rotman then had Petitioner lift her arm and at first she would only lift it to 45 outwards and 30 in front of her the way to make a diagnosis of frozen shoulder is in external rotation and he took an arm and externally rotated it with the arm at the side and both shoulders had 65 degrees. Petitioner had equal rotation on both sides. (Rx-3, T.16) So by definition, Petitioner did not have frozen shoulder.

The clinical significance of atrophy is that if Petitioner had dystrophy of her shoulder, she would have shrinkage of the muscle around her arm and shoulder. (Rx-3, T.16) Petitioner reported she had these problems for a long time and if she truly had dystrophy for this long of a time or frozen shoulder for as long as there was this diagnosis, Petitioner would have significant shrinkage of muscle or significant atrophy.

Petitioner's strength was tested and when she would lift it up, he would touch her arm and Petitioner would drop it right down which was a pretty clear way to diagnose lack of effort. Dr. Rotman then performed certain tests for rotator cuff tears and biceps tears. (Rx-3, T.17) The tests are called supraspinatus and Speed's testing. Interesting findings were noted with regards to pain responses when he tested for rotator cuff pain, Petitioner instead had pain going down the radial side of the forearm into the thumb and then went all the way up her arm which made no sense at all for that test. He then tested for biceps pain which is the Speed's testing and instead she had pain starting in her arm going down the palmer surface or volar surface of her mid forearm. These two responses were non-physiologic which means they made no sense anatomically.

When Petitioner tested for biceps pain which is called the Yergason's test, Petitioner had outer deltoid discomfort and when he rotated her shoulder she had pain in the back of it. (Rx-3, T.18) If Petitioner had a

biceps tear, she would have pain in the biceps. In this case Petitioner had no pain in the biceps. There was multitude of non-physiological responses when Dr. Rotman tapped over various objects or areas of the arm. When he tapped the clavicle which is the mid-aspect of the clavicle and shoulder which is just a bone, Petitioner had a shock wave discomfort over the top of her forearm and hand and then numbness into the middle, ring finger small fingers. Having numbness from tapping over the collarbone is a completely impossible finding and it made no anatomical sense which he characterized as non-physiologic.

When Dr. Rotman tapped the anconeus muscle over Petitioner's outer elbow, it caused pain on the palm and palmer surface of the forearm all the way down to the fingers which is impossible. (Rx-3, T.19) When Dr. Rotman tapped over the right cubital tunnel at the inner elbow, Petitioner not only described numbness just going into the ring and small fingers but also into the middle finger. Petitioner then had volar forearm discomfort and numbness on the top of her hand and that would be non-physiologic because the cubital tunnel nerve does not go in that area and it would not go into the volar forearm area. When Petitioner was tested over the carpal tunnel, it caused all of her fingers to go numb outside of her thumb.

On further examination, Petitioner had no contracture and had full range of motion, and made a fist. (Rx-3, T.20) Petitioner displayed no allodynia. Allodynia is a sign of dystrophy where a person can't touch the skin. Dr. Rotman had no problem touching her skin. Petitioner's sweat was normal. Blood flow was normal. Petitioner's color was normal with the Allen's testing where that is the test of the arteries of the hands. With the grip strength testing, where she had a completely normal hand with no muscle loss and full range of motion, she hardly generated any grip a complete lack of effort similar to the testing of the shoulder. With carpal tunnel testing, he would expect to see findings in the middle finger and maybe the index but it would not go into the small finger.

Dr. Rotman's impression was that Petitioner had no evidence of dystrophy based on the bone scan. (Rx-3, T.21) Petitioner also had normal nerve studies in the lower extremities and no evidence of nerve injury, no fractures in ankle and no significant strains. Concerning the right shoulder, Petitioner had an old degenerative superior labral region that had been noted on her original MRI scan that was associated with cysts. Petitioner was very active in the past and had been very active in sporting and it was not surprising that she might have an old superior labral lesion with a cyst. Having a cyst means it had been going on for a long time. This was not the cause of Petitioner's problems. Petitioner had no evidence of a frozen shoulder. Petitioner had no dystrophy in the upper extremities. Petitioner had a multitude of non-physiologic responses and magnification in perceived impairment. Petitioner did not have an objective correlation to those problems that she thought she had. Dr. Rotman believed Petitioner was fairly normal as far as her upper extremities.

Dr. Rotman believed Petitioner's treatment was prolonged and he believed her care should have been stopped immediately as soon as her treaters figured out she did not have any problems instead of just basing her care on subjective complaints.

Petitioner was on high doses of narcotics and in fact was on narcotics before she was even injured and on multiple psychologic medications before the injury. (Rx-3, T.23) There is an obvious problem with the narcotic usage and narcotic prescribing which is inappropriate. He felt most of her case was absurd. Dr. Rotman opined there was no reason for Petitioner to have any restrictions as she had a normal right arm and normal ankle with no evidence of an injury. Petitioner should have been back to full duty quickly after the incident.

Dr. Rotman believed Petitioner had reached MMI within three to four weeks of her accident assuming she had a minor ankle strain and right arm strain. (Rx-3, T.24)

When Dr. Romeo indicated Petitioner had a labral tear, it is the same thing as a labral lesion. (Rx-3, T.27) It was Dr. Rotman's opinion the tear pre-existed the injury.

Most tears are asymptomatic. (Rx-3, T.28) Superior labral lesions are pretty common, especially in throwers and athletes. Generally, when there is a cyst in an area, there was some type of lesion in the labrum associated with the cyst as a cyst is secondary to a labral lesion.

Trauma can be one of the instigating factors in making a cyst symptomatic. (Rx-3, T.30) Dr. Rotman could not perform a physical exam on Petitioner's foot as she had a boot. Dr. Rotman stated he was not particularly asked to examine the ankle but had became more obvious as he was reviewing the records and putting everything together that he felt it was important to talk about the ankle issues.

Dr. Rotman reviewed Dr. Boutwell's report that Petitioner suffered from brachial plexus abnormality in her right shoulder, but testified he thought she deferred her opinion on that issue to a shoulder specialist. (Rx-3, T.31) Dr. Rotman opined that CRPS gets better over time and it doesn't wax or wane. (Rx-3, T34)

In the social history provided by Petitioner, she informed Dr. Rotman she used to play softball, basketball, and golf as well as some park district sporting activities. (Rx-3, T.36) Petitioner reported she was less involved in these types of injuries up until May 2014. The sporting activities that she discussed would be activities Dr. Rotman would normally see lesions in the shoulders.

If Dr. Romeo recommended a shoulder surgery, the prognosis would be horrible just like the stellate ganglion block Petitioner had. (Rx-3, T.37) If Petitioner truly had a frozen shoulder, Dr. Rotman would just do a manipulation and not do a surgery. The minor lesion of the superior labrum generally doesn't require treatment.

Dr. Boutwell Deposition

Dr. Boutwell is board certified both by the American Board of Anesthesiology as well as the American Board of Pain Management. (Rx-7, T.6) Dr. Boutwell is also certified by the American Board of Independent Medical Examiners.

At the time of the April 24, 2015 examination, chief complaints were to the left foot and right shoulder status-post a fall that occurred on July 31, 2014. (Rx-7, T.10) Petitioner reported globally her discomfort range between 8/10 and 10/10 that purportedly improved with taking of medications and receiving injections. (Rx-7, T.13) With respect to the left lower extremity, Petitioner could not describe much in the way of allodynia although she described some changes in hair growth that Dr. Boutwell was not able to appreciate because Petitioner shaved her legs and Petitioner was able to tolerate the shaving of her legs. (Rx-7, T.13)

To clarify, Petitioner actually reported 7 to 10 and 8 out of 10 in pain. (Rx-7, T.14)

On physical exam of the left foot, Dr. Boutwell did not notice any signs of atrophy in either the muscle or bony structures. (Rx-7, T.15) The ankle was cleanly shaven, indicating Petitioner able to tolerate that type of tactile stimulation. Dr. Boutwell did not appreciate different hair pattern on the right compared to the left. The nail pattern on Petitioner's bilateral feet looked normal and were symmetric. The only significant finding in the left included some change in temperature and that the left foot did in fact feel slightly cooler than the right to touch.

Range of motion of the left hind foot did seem significantly restricted in nearly all planes versus the right. (Rx-7, T.16) Petitioner was wearing a CAM walking boot that had apparently been using the CAM boot for a prolonged period of time. That type of hind foot restriction is a problem that physicians try to avoid by not

keeping a patient in the CAM boot that long. Petitioner predominately had stiffness related to having been booted for that long. Atrophy is a common feature after having these types of CAM walking boots but Petitioner did not appear to have any significant or even apparent atrophy.

Petitioner had very little in the way of allodynia, meaning light touch did not provoke a report or sensation of discomfort or provoke any pain behaviors. (Rx-7, T.17) Petitioner did not have any discrete areas of tenderness with the exception of just over the dorsum of the foot at the ankle area. No significant finding of edema or swelling nor was there sweating of the foot noted and no significant instability noted. As far as the right shoulder was concerned, Petitioner had significant tenderness to palpation directly over the anterior and posterior joint line and Petitioner remarked having maximal tenderness in the right trapezia musculature. No discrete trigger points. Range of motion of the right shoulder was restricted and abduction.

Apprehension testing appeared positive for pain in the posterior aspect of the right shoulder. (Rx-7, T.18) Cross-body and Neer's testing were difficult to ascertain because of Petitioner's subjective complaints of discomfort really prevented full range of motion. The appearance of the bilateral hands appeared symmetric and normal.

Dr. Boutwell describes the photos that she had taken. (Rx-7, T.19-22)

Dr. Boutwell did not document any specific temperatures between the feet. (Rx-7, T.22) Petitioner's blood supply in the left foot seemed essentially symmetric with the right.

Petitioner's capillary refill on both the left and the right lower extremity including the toenail bed was brisk and symmetric which would be normal. Whatever might have been going on from a sympathetic nervous system or vascular standpoint had to add a minimum reversible component that was not present when Dr. Boutwell examined Petitioner nor were there any signs of problems being overtly chronic which can result in clubbing of the toenails and fingers.

When considering the diagnosis of complex regional pain syndrome it is always based on a constellation of findings and imaging and diagnostic testing and evaluation besides the physical examination, diagnostic testing is really where the decision is clarified if possible. (Rx-7, T.25) The left ankle x-ray of July 31, 2014 demonstrated an 8 mm bone fragment adjacent to the tip of the lateral malleolus that was compatible with an old remote trauma but otherwise negative. There was an MRI of the left ankle without contrast on October 1, 2014 which remarked upon some fibers of the anterior talofibular ligament which appeared indistinct, potentially as a result of a prior sprain or partial tear and showed some minimal fluid signal within the flexor digitorum and flexor hallucis tendon sheaths but otherwise intact.

The MRI of the right shoulder dated October 16, 2014 demonstrated presumed underlying labral tears. (Rx-7, T.25) There was a sweat test dated December 11, 2014 that was considered abnormal with respect to the left foot and normal on the right which was positive. (Rx-7, T.26) There was a three phased bone scan from Carle Foundation Hospital which demonstrated no evidence of abnormal uptake in the left ankle which would argue against the presence of a RSD clinical picture. Petitioner reported she had an EMG that was normal.

The EMG came back normal which would be similar to the three phased bone scan that was negative for abnormal uptake so both of those would argue strongly against the presence of complex regional pain syndrome of the right shoulder, especially at the juncture of the time after the injury. (Rx-7, T.27) Complex regional pain syndrome typically has to have time to truly evolve and it is typically accepted at least three to six months is necessary before a diagnosis of complex regional pain syndrome can be made.

It was Dr. Boutwell's opinion that Petitioner's right upper extremity complaints did not meet any of the criteria for the diagnosis of complex regional pain syndrome. (Rx-7, T.28) It appeared she had an ongoing labral issue which could explain the internal derangement of the right shoulder which could explain pain in that area. The history of the candle wax fingers that sounded more like a diagnosis of Raynaud's was not present.

With respect to the left ankle and foot, Dr. Boutwell left open the question of complex regional pain syndrome given Petitioner's description of discomfort after a relatively minor injury with no evidence of an acute boney injury. (Rx-7, T.29) Even the fragment of bone that appeared in the x-ray had distinct features that indicated it had been pre-existing and what was likely an incidental finding. In an effort to address those complaints, Dr. Boutwell recommended the possibility of repeating the sympathetic nerve block to determine if there was a sympathetically maintained pain syndrome. Petitioner had responded favorably to the sympathetic block provided historically which would argue in favor of a sympathetic maintained pain syndrome. However, that would not necessarily be CRPS. It could again, like with the history of the right upper extremity, be kind of a Raynaud's type phenomenon. That could have very likely been going on in a lower extremity as well and be diffuse in the peripheral capillary bed so even if Petitioner got a sympathetic block, it could help with that diagnosis as well.

The three phased bone scan which was done in February 2015 would have given the diagnosis of CRPS sufficient time to have started wrecking the kind of havoc that it does when it is present and it would have been anticipated Petitioner's bone scan would have been positive at that point for some type of boney change relative to sympathetic malfunction and it did not. (Rx-7, T.30)

Petitioner's sweat test argues in favor of an abnormal vasomotor condition. (Rx-7, T.31) This would have been consistent also with the fact on the date of exam on December 11, 2014, Petitioner's left foot was cooler to touch on the left compared to the right and there was some color discrepancy which fit some of the criteria for complex regional pain syndrome. But there was no other significant atrophy or disuse atrophy after Petitioner wearing a CAM boot more than would be advised which raised some questions regarding the validity of the diagnosis of CRPS.

There is a criteria that are considered for CRPS which are utilized by the American Medical Association Guidelines. (Rx-7, T.31-33) The Budapest Criteria requires a constellation including:

1. Continuing pain disproportionate to the inciting event;
2. At least one symptom out of the categories of sensory, which include hyperalgesia or allondynia which Petitioner did not have as she was able to shave her legs and Dr. Boutwell noted her CRPS patients can't tolerate this activity wherein they cannot tolerate even light touch much less the elective procedure of shaving.

Next would be vasomotor which is reports of temperature asymmetry or skin color changes or skin color asymmetry which was present. Next would be reports of edema or sweating changes which Dr. Boutwell did not appreciate any significant edema and Petitioner did not complain of any swelling on a regular basis. The sweat test was reportedly abnormal but Petitioner's leg wasn't sweating when Dr. Boutwell saw her nor did Petitioner complain of any abnormal sweating. There was no motor dysfunction or trophic changes in the hair, skin or nail pattern. Petitioner did have a restricted ranged of motion. Dr. Boutwell was more concerned the restricted range of motion had more to do with Petitioner wearing a CAM walking boot for months. The next diagnostic criteria are displaying at least one sign at the time of the evaluation of two or more of the following categories; again, sensory would be evidence of hyperalgesia, meaning light touch results in excruciating complaints of discomfort and Dr. Boutwell was able to exam Petitioner both with firm pressure, light touch, and manipulation of the shoulder and ankle without any reports of discomfort of that nature.

Petitioner's report in having a railroad spike in her ankle or vice-like squeezing was not demonstrated pain behaviors on exam that would be consistent with Petitioner's complaints. Dr. Boutwell was able to manipulate her ankle, light touch and pressure diffusely without a complaint of specific pain in any one area. Dr. Boutwell was able to press an area without Petitioner basically wanting to grab a chandelier and when the area was pressed it would blanch meaning that the skin was still normal in color and that the capillary feels normal but the underlying vasomotor bed was dilated demonstrating no actual skin change.

There was no smoothing of the skin or thickening of the skin that would be typically apparent of CRPS. (Rx-7, T.35) The next factor is sudomotor edema which would be evidence of edema or sweating changes or seating asymmetry. In exam, there was no evidence of edema noted nor was there evidence of chronic edema. In exam, Petitioner had an objectively abnormal sweat test historically but that was not present in the date of examination. Going to the next factor, motor and trophic signs, including evidence of decreased range of motion, Dr. Boutwell noted there was no tremor, no dystonia and no apparent weakness.

To the fourth factor, which is no better diagnosis that explains the signs or symptoms. Dr. Boutwell did not believe it fit because there was not a lot of the signs and symptoms that she was looking for. (Rx-7, T.36)

Dr. Boutwell indicated Petitioner could potentially exist on the very, very, very mild end of CRPS from the perspective of the left ankle but her right shoulder did not fit in with CRPS. (Rx-7, T.37) With respect to the left ankle, there were certain minor features that could have indicated that in diagnosis. Based on Dr. Boutwell's experience with the disease, she believed it was more likely she had an underlying probable vasomotor dysfunction similar to what she had in the right hand which Dr. Boutwell did not believe was related to the injury and Petitioner had some persistent neuritis of some sort in the area that potentially caused those vasomotor changes to become more significant. Dr. Boutwell is familiar with Raynaud's syndrome as she has it herself.

Raynaud's syndrome can also effect the lower extremities. (Rx-7, T.39) A rheumatologically specialist is typically who one would see for treatment of this condition. The Raynaud's disease could be a condition that could explain Petitioner's temperature difference between the left and right feet.

It was Dr. Boutwell's opinion that the medical treatment rendered as the date of her IME was acceptable. (Rx-7, T.40) For treatment recommendations, Dr. Boutwell would defer to an orthopedic surgeon as to the orthopedic issues.

For questionable history of CRPS and essentially giving Petitioner the benefit of the doubt, Dr. Boutwell indicated it would be well advised to acknowledge the possibility that some component of sympathetic dystrophy might exist. (Rx-7, T.41) But under the circumstances, Dr. Boutwell recommended proceeding with the second sympathetic nerve block to essentially confirm the condition or at least confirm there was a sympathetic component to her ongoing complaints. At that point, a decision could be made to continue in that direction versus change directions and therapy.

If a person did have CRPS in the lower extremity, it would absolutely have an impact as to their gait or walking. (Rx-7, T.42) Most patients with CRPS in the lower extremity cannot tolerate for the leg to be touched much less walk on it.

If evidence at trial revealed Petitioner walked with a normal gait subsequent to Dr. Boutwell's examination, Dr. Boutwell testified it would certainly impact her opinion of the diagnosis in that she could clearly rule out CRPS if Petitioner was ambulating normally. (Rx-7, T.43)

Dr. Boutwell believed gainful employment would be an option for Petitioner but based on Petitioner's degree of subjective complaints that she presented with at the day of the appointment, Petitioner was pretty clear she would not have sustained a return to work in any level. (Rx-7, T.43) Petitioner made it very clear that returning to work in any capacity was not something she felt she could sustain.

Dr. Boutwell did not believe Petitioner had reached MMI. (Rx-7, T.44) Dr. Boutwell believed that an additional evaluation of therapy would be of benefit either therapeutically and/or diagnostically.

In order to determine MMI for the right shoulder, Dr. Boutwell would need to know what the surgeon had determined for the underlying issue and if it felt surgery was necessary. (Rx-7, T.45) With respect to the left foot, MMI could be determined after performing the second sympathetic nerve block and seeing what happens and taking it from there. Ideally, Petitioner would become asymptomatic with some type of treatment or time or if she had remained symptomatic then when she had reached a stable therapeutic plateau that was not anticipated to change.

The majority of the most reliable testing argues against the objective presence of CRPS. (Rx-7, T.47)

If a repeat block or a series of two to three blocks did not provide a normal relation of temperature or a report of improved discomfort then that is when a physician can call it a day and it is unlikely that whatever complaints Petitioner is reporting subjectively are the results of an objectively verifiable diagnosis. (Rx-7, T.48)

Dr. Boutwell was trained to identify someone who is drug seeking and Dr. Boutwell did not think that Petitioner was drug seeking. She noted no red flags in that regard. (RX-7 T. 50-51) Dr. Boutwell also admitted she was given medical documents that predate the accident but did not see any indication that Petitioner had similar complaints to her shoulder and ankle that predate her injury. (RX-7 51)

Dr. Boutwell did review the December 11, 2014 sweat test which is an objective study that accounts for sympathetic and parasympathetic response to stimulus. (Rx-7, T.52)

An abnormal sweat test can indicate that the neurologic function and regulation in a certain body area is improperly regulated or not and if there is a discrepancy it would be a sign of some type of short circuit in the neurologic wiring. (Rx-7, T.53)

Dr. Boutwell's diagnosis was questionable upper extremity neuritis versus complex regional pain syndrome. (Rx-7, T.55) When Dr. Boutwell states questionable she means not essentially. The reason Dr. Boutwell wrote questionable is that at some point in the report someone had questioned the possibility of CRPS because of symptoms Petitioner was having in her hand.

Dr. Boutwell did not believe Petitioner had CRPS in the hand or arm. Dr. Boutwell intended to communicate in her report that the diagnosis had been questioned but in her opinion was not present. (Rx-7, T.56) Dr. Boutwell did notice a temperature variance between the feet.

The differentiation in feet is an objective result of a CRPS possible diagnoses. (Rx-7, T.57) The pictures that Dr. Boutwell took did demonstrate some color discrepancy which was another part of the constellation for CRPS. CRPS is a condition that can wax and wane.

The end result of CRPS over time creates signs of a chronic condition. (Rx-7, T.58) With CRPS and at the juncture Dr. Boutwell saw Petitioner, it would have likely resulted in more sort of irreversible unchanging

features such as defused smoothing of thickening of the skin or significant changes in the hair which Dr. Boutwell did not appreciate as the legs were shaven. The nails tend to look either very thick, very thin, very long and you can't touch them.

There are different levels of severity of CRPS. (Rx-7, T.59) If things went the direction of diagnosing Petitioner with CRPS, Petitioner would definitely be on the very, very mild end of that spectrum. It is possible for somebody to carry a CRPS and not exhibit all the classical symptoms of CRPS.

Dr. Boutwell believed Petitioner suffered pathology consisting of inflammatory and neuropathic pain related to intrinsic right shoulder pathology as well as potential contribution of right brachial plexus abnormality consistent with the history of mechanical trauma. (Rx-7, T.60)

Brachial plexus abnormality would be potentially like a stretch of the network or nerves that exit the neck and go to the shoulder. (Rx-7, T.61) It is relatively common to see these types of irritations and exacerbations after the type of mechanism of Petitioner's injury.

If Dr. Lubenow performed the ganglion block as recommended by Dr. Boutwell and Dr. Lubenow felt Petitioner's symptoms were controlled or minimal enough where she could seek surgical intervention from both the shoulder and ankle, it would be something Dr. Boutwell would consider a positive result. (Rx-7, T.62)

If Petitioner had the block and her symptoms remanded sufficiently enough to proceed with surgery would sound like a positive outcome but Dr. Boutwell did not know if that becomes a diagnostic tool for CRPS. (Rx-7, T.63) Dr. Boutwell felt Petitioner is subjectively perceived limitations would prevent her from sustaining work if she was forced to return.

With the knowledge Dr. Boutwell had as the date of the deposition, she could not say for sure if Petitioner had CRPS based on the information she had. (Rx-7, T.64) Dr. Boutwell believed Petitioner had pretty good mobility. Petitioner was able to walk around for the most part. Petitioner seemed to be able to walk around fine as long as she was wearing her CAM boot.

Dr. Boutwell stated that for her IME patients, they are typically observed from approximately the time they enter the building to getting to the office suite to being roomed until they leave the premises. (Rx-7, T.65) It was Dr. Boutwell's opinion that Petitioner's ambulation was fairly preserved. Dr. Boutwell made all of her findings in her report and treatment recommendations even after observing Petitioner's gait. (RX-7, T. 65) For the injection Dr. Boutwell proposed, it is possible it could have a placebo effect.

On the date of Dr. Boutwell's examination, Petitioner felt she was demonstrating her typical symptoms. (Rx-7, T.66) Petitioner indicated she felt that her leg was significantly affected on that day. Accordingly, Dr. Boutwell believed she was given a reasonably reliable objective opportunity to exam Petitioner that day.

Deposition of Dr. Holmes

Dr. Holmes testified he performed an Independent Medical Examination on Petitioner on January 28, 2015. (Rx-5, T.8)

Dr. Holmes reviewed Petitioner's x-rays of July 31, 2014, August 5, 2014 and an MRI from September 30, 2014. (Rx-5, T.10) In reviewing all of the studies, it did not appear Petitioner sustained an acute injury. From a forensic standpoint, the initial x-rays of July 31, 2014 delineated an old injury.

Dr. Holmes' physical exam was limited. (Rx-5, T.13) He was able to take measurements of the calf, left and right. He was unable to do any further measurements on the injured side as Petitioner indicated she had significant pain to light touch to any portion of her foot, both on the top, the side, the medial side of the foot and the bottom of the foot. He was not able to actually grab the foot or do any manipulation of the foot, secondary to Petitioner's reported areas of pain. Dr. Holmes did not detect any change in skin color or temperature difference.

Dr. Holmes' diagnosis is that Petitioner did not sustain an acute fracture and did not sustain an acute ligamentous injury by virtue of the MRI scan that was taken. He felt she did have a neurologic component to her pain but he had verbal indication from Petitioner of a normal EMG. (Rx-5, T.14) Dr. Holmes opined Petitioner did not have complex regional pain syndrome. This was from his opinion as an orthopedic surgeon. He does treat patients with this disorder and consultation with pain management.

The parameters to complex regional pain syndrome involving sweating, redness of the skin, atrophy, hair pattern changes, or temperature changes. (Rx-5, T.15) He did not see those present. An important issue was the history from Petitioner that she had severe pain that caused her to have nausea and then she also described having severe numbness and tingling that was profoundly noted from the foot to the ankle. Petitioner noted her ankle was very unstable and very weak. Petitioner described burning pain to the foot that radiated to the low back. Petitioner described having a crushing pain and nothing made the pain better. Petitioner stated she used a cam walker boot and a roll-a-bout and totally non weight bearing and had remained off work. Petitioner described her pain as sharp, tingling, aching and throbbing, involving the entire leg from the foot to the heal, ankle and up the leg.

Putting all those symptoms on a check list, Petitioner cannot be using the leg to the same extent that she is using the other leg. (Rx-5, T.16) Petitioner had no significant atrophy in comparing the right and left lower extremities. Petitioner had essentially a normal measurement between the left and right calves which he felt was inconsistent with someone who had not been walking and had been using a roll-a-bout and a boot. Dr. Holmes would have perceived far more atrophy than was demonstrated.

Dr. Holmes noted on his examination of the foot was essentially numb when he tried to wiggle her toes and touch areas on the foot to determine if she could determine if he was touching her great toe, second toe or small toe. Petitioner had almost complete anesthesia with that maneuver that had exquisite pain to light touch over the distal aspect of the fibula. (Rx-5, T.17) Petitioner indicated she was unable to feel anything at all when he touched the toes and the foot. This told Dr. Holmes clinically that there was a discrepancy between that report and essential a normal EMG and on the other hand Petitioner described exquisite pain with light touch. It is hard to have anesthesia in that level of pain.

Dr. Holmes could not find anything orthopedically that would explain why Petitioner was having pain over the tip of her fibula. (Rx-5, T.18)

Dr. Holmes took photos to document the appearance of both feet were the same to show there was no increased swelling between the right and left feet. There was no atrophy between the left and right foot on the photographs. (Rx-5, T.19) Dr. Holmes could not find any organic or orthopedic findings to explain Petitioner's pain or subjective complaints.

The numbness over one spot in the fibula that was very sensitive would be inconsistent with a normal verbal report of the EMG. (Rx-5, T.20) Dr. Holmes did not believe the manipulation under anesthesia was necessary due to the MRI findings and x-ray findings.

Dr. Holmes did not feel Petitioner needed an examination under anesthesia for the stability reasons, by virtue of the fact Petitioner's MRI scan did not demonstrate any significant ligamentous injury that would warrant an examination under anesthesia. (Rx-5, T.21) Dr. Holmes did not believe the bone fragment that was seen in the diagnostic studies needed to be removed as a result of the injury. His opinion was based in part because the fragment was old and if there had been some aggravation of the bone fragment as a result of the injury, it would have also shown up on the MRI as some collateral damage. There would have been some bleeding in that area and effusion.

If the bone had been injured further, there would be signal change within the bone. (Rx-5, T.22)

It was Dr. Holmes' opinion that the injury did not aggravate the prior fracture. (Rx-5, T.23) Dr. Holmes did not have any treatment recommendations from an orthopedic standpoint. Dr. Holmes did believe it would be reasonable for Petitioner to proceed with pain management given her level of subjective complaints. Pain management is not an area that he specializes in. From an orthopedic standpoint, he did not see an injury to her foot or ankle. Dr. Holmes opined Petitioner reached MMI from an orthopedic standpoint. (Rx-5, 23)

Dr. Holmes stated that with respect to the pain syndrome, it may be helpful to get a second set of eyes to determine MMI. (Rx-5, T.24) From an orthopedic standpoint, Dr. Holmes did not believe Petitioner required any work restrictions as it related to a foot or ankle.

Dr. Holmes believed Dr. Lubenow's documentation of reported symptoms of edema, temperature changes, erythema, shiny skin and severe allodynia was and was not consistent with a sprain-strain injury. (Rx-5, T.27) Dr. Holmes stated that with a sprain or strain, a person can get edema and some mild temperature changes. In a general sense, there are people that get RSD or chronic regional pain syndrome from a sprain or strain.

Dr. Holmes believed there was more of a neurological issue than CRPS for Petitioner's left ankle. (Rx-5, T.28)

Dr. Holmes was aware Dr. Lubenow had seen Petitioner and he was looking for another set of eyes other than Dr. Lubenow's. (Rx-5, T.29)

CRPS can wax and wain to an extent but there usually is a baseline. (Rx-5, T.30) If a person doesn't walk, they lose muscle tone really quickly whether they are an athlete or a normal person. One would anticipate with the severity of pain that was being mentioned to the point that Dr. Holmes was not able to touch Petitioner he would anticipate some measure of atrophy comparing the right and left lower extremities.

If another physician later examined Petitioner and thought Petitioner may have CRPS, Dr. Holmes would defer his opinion to the pain specialist. (Rx-5, T.31)

Dr. Holmes' opined Petitioner did not have RSD. (Rx-5, T.34)

LEGAL CONCLUSIONS

The main dispute in this file involves causation. Respondent agreed that Petitioner injured herself on July 31, 2014 but disagrees to the extent of Petitioner's injuries and the medical treatment involved. Petitioner suffered two main injuries on that date; one to her right arm/shoulder and the other to her left foot.

Causation and prospective medical regarding Petitioner right arm/shoulder

As stated, it is undisputed that Petitioner fell on her right arm/shoulder on the date in question. What is in dispute is the extent of the damage of this injury. The Arbitrator notes that Petitioner had immediate right arm/shoulder complaints upon her admission to the ER the day of the accident. The Arbitrator also notes that Petitioner consistently complained about her right shoulder and it was noted by Dr. Cohen, an occupational physician, that the mechanism of injury certainly could manifest as trauma to the rotator cuff and glenoid labrum. It was also noted in his physical exam by Dr. Gurtler, orthopedic shoulder physician, that Petitioner had a scar on her right elbow consistent with a significant blow to that body part. But due to the neurological elements and concern for CRSP he sent Petitioner to see a shoulder specialist in Chicago.

Dr. Romeo examined Petitioner and noted that she had disproportionate responses to his physical exam. However, during his testimony Dr. Romeo made it clear this was the reason he wanted Petitioner to complete her treatment with Dr. Lubenow before he would exam Petitioner again for possible surgery to correct her shoulder injury. Dr. Romeo was concerned with a diagnosis of CRPS in Petitioner's shoulder or he felt that brachial plexus to her right shoulder was consistent with her injury and her pain complaints. Further, Dr. Romeo testified he thought the fall in question rendered a degenerative condition symptomatic or even possibly made some acute changes to Petitioner's shoulder.

Dr. Lubenow also testified in regards to Petitioner's right shoulder. Dr. Lubenow did not believe Petitioner suffered from CRPS in her right shoulder. However, he did believe that the Petitioner suffered right upper extremity pleopathy along with a right shoulder labral tear. Dr. Lubenow testified that brachial plexopathy was usually a result of trauma and that was happened in this case.

Respondent argues that the testimony of Dr. Rotman should be found more credible than the testimony of Dr. Lubenow and Dr. Romeo and especially relies on the findings that Petitioner's right shoulder showed little to no atrophy during examination. The Arbitrator finds these arguments to be unpersuasive. Dr. Rotman did not limit his exam to just Petitioner's shoulder but felt obligated to comment on Petitioner's left ankle as well. Dr. Rotman gave these opinions even though he did not even physically examine Petitioner's left foot. This immediately puts Dr. Rotman's credibility into question. It was also noted by the Arbitrator that Dr. Rotman based his opinions on that fact that he thought Petitioner was clearly malingering and exaggerating all of symptoms. Based upon the fact he thought Petitioner was a malingerer, Dr. Rotman testified that Petitioner's treatment had been excessive and almost all of it unnecessary.

However, this is problematic in light of Respondent's other testifying physician, Dr. Boutwell. Dr. Boutwell testified as a pain specialist she is specially trained to note if she thought Petitioner was exaggerating pain complaints. However, in this claim she did not note that she thought Petitioner was exaggerating or malingering. She also contradicts Dr. Rotman on the reasonableness of treatment regarding the Petitioner. Dr. Boutwell even restricted Petitioner from work for her work related condition. Even more noteworthy is that Dr. Boutwell agreed with the diagnosis of Dr. Lubenow and Dr. Romeo that Petitioner suffered right shoulder pathology as well as potential contribution of right brachial plexus abnormalities consistent with mechanical trauma.

Based upon the fact that three of the four testifying physician's, one of which was Respondents, opined that Petitioner suffered right brachial plexus of her right shoulder as a result of her injury the Arbitrator finds in

favor of the Petitioner that on July 31, 2014 Petitioner suffered an injury to her right shoulder resulting in a possible labrum tear, that will need surgical evaluation and right bracial plexus injury to her right shoulder which requires pain management.

Causation and prospective medical regarding Petitioner's left ankle/CRPS

Petitioner has consistently complained that she has had severe pain in her left ankle since her July 31, 2014 date of injury. Petitioner described an inversion twisting injury on that date and x-rays did display a fracture. Dr. Grambart testified he thought the injury could have either caused the fracture displayed or aggravated a pre-existing fracture causing it to be symptomatic. He further testified that although he is not an expert on CRPS, he thought Petitioner suffered from that condition in her left ankle as well which was as a result of the trauma which is why he recommended surgery to help correct the structural problem in Petitioner's left ankle only after she had been cleared for treatment by Dr. Lubenow.

Dr. Lubenow also testified that the Petitioner suffered from CRPS in her left ankle. He used the Budapest criteria to come to this conclusion. A criteria he testified is the current standard for evaluation of CRPS claims and he helped develop. It was doctor Lubenow's testimony that Petitioner suffered from CRPS in her left ankle as a result of the injury in question. This opinion was made more credible due to the fact that Dr. Lubenow did not think Petitioner suffered from the same condition in her right shoulder. Dr. Lubenow's testimony appeared both reliable and credible.

Dr. Boutwell who examined Petitioner's left ankle for Respondent certified all of Dr. Lubenow's treatment that has occurred to date and even left the possibility open that Petitioner may have CRPS in her left ankle. It was also noted by the Arbitrator that Dr. Boutwell used the Budapest criteria when she examined the Petitioner for possible CRPS. Dr. Boutwell even certified that treatment recommendations of Dr. Lubenow and related them casually to Petitioner's injury.

It is true that Dr. Holmes disagreed with the diagnosis of CRPS but he admitted that would defer his opinion's to a person with more specialization in the area. Dr. Holmes only put Petitioner as MMI at the time of his exam as an orthopedic physician but not as a pain specialist. Dr. Holmes also admitted that CRPS could occur as a result of an injury such as suffered by the Petitioner. In regards to the structural problems in Petitioner's ankle, Dr. Holmes disagreed with the treatment recommendations of Dr. Grambart. He partially based this conclusion upon that he did not think Petitioner had enough atrophy in her left ankle to demonstrate the lack of use she described. However, this conclusion conflicts with an ultrasound taken by a Dr. Zimmerman at Carle Hospital that demonstrated marked atrophy in Petitioner's left ankle tendons.

Therefore, the Arbitrator finds the testimony of Dr. Lubenow and Dr. Grambart more persuasive then those of Dr. Holmes and finds that Petitioner did suffer injury to her left ankle that resulted in her diagnosis of CRPS and need for surgical intervention as performed by Dr. Grambart. Dr. Holmes admitted that while he did not think Petitioner suffered from CRPS he still recommended further pain management and deferred to their expertise in regards to CRPS.

Disputed TTD

Having found in favor of the Petitioner in regards to causation, the Arbitrator further awards Petitioner TTD benefits for 8/1/2014-6/15/2017 or 150 weeks subject to the credit of benefits already paid by Respondent. This

is based upon the restrictions placed by Dr. Cohen, Dr. Grambart, and even Respondent's physician Dr. Boutwell who restricted Petitioner from work and it appeared never released her.

Other Issues

Petitioner requested that Respondent pay for travel costs for Petitioner to see Dr. Romeo. As it is clear from the record that Petitioner was sent out of region for medical examination the Respondent shall pay those expenses.

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lavern Huggins,

Petitioner,

vs.

NO: 11WC 13639

River Bluff Nursing Home,

Respondent.

18IWCC0425

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of 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.

This matter was tried in conjunction with consolidated cases 11WC 13638 and 11WC 24778. However, Petitioner's Petition for Review filed December 22, 2016, on case 11WC 13638 was previously withdrawn and no decision will be issued at this time.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 1, 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.

18IWCC0425

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: JUL 12 2018
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KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUGGINS, LAVERN
Employee/Petitioner

Case# **11WC013639**

11WC013638
11WC024778

RIVER BLUFF NURSING HOME
Employer/Respondent

18IWCC0425

On 12/1/2016, 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 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5511 DeCARLO LAW GROUP
ANITA M DeCARLO
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

0563 WILLIAMS & McCARTHY LLP
CAROL HARTLINE
120 W STATE ST SUITE 400
ROCKFORD, IL 61101

18IWCC0425

STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lavern Huggins
Employee/Petitioner

Case # 11 WC 13639

v.

Consolidated cases: 11 WC 13638
11 WC 24778

River Bluff Nursing Home
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **July 19, 2016 and October 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 **March 14, 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.

In the year preceding the injury, Petitioner earned $**23,052.12**; the average weekly wage was $**443.31**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** dependent children.

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

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

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

Respondent paid benefits of $**23,651.80** under Section 8(j) of the Act.

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT ON MARCH 14, 2011, THIS CLAIM FOR COMPENSATION IS DENIED.

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

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

Signature of Arbitrator

December 1, 2016
Date

ICArbDec p. 2

DEC 1 - 2016

Statement of Facts

This matter was tried in conjunction with consolidated cases 11 WC 13638 (date of accident March 17, 2010) and 11 WC 24778 (date of accident October 18, 2010). These matters were consolidated for hearing and a single transcript was prepared. The Arbitrator has issued separate decisions with respect to each of these claims.

Petitioner Lavern Huggins testified that she was employed by Respondent River Bluff Nursing Home as a certified nursing assistant since 2006. Respondent provides skilled care for geriatric patients. Petitioner testified her duties included bathing the residents. She would transfer them to the shower using a gait belt. If she needed to clean them outside of the shower, she would use a basin and water. She would turn and roll the resident. Most of the time there would be two people to do this. She used Hoyer lifts to move and lift the residents. Petitioner testified there are three wings to the home. There are 12 to 14 residents to one CNA. There are 3 CNAs when the shift is properly staffed. In early 2010, they were not fully staffed. There were one or two CNAs.

Petitioner testified that on March 17, 2010, she was lifting a resident with another person and started having weakness and pain in her right shoulder. Petitioner identified Petitioner's Exhibit 1 as the reporting she prepared at that time. She sought treatment at Brookside Immediate and Occupational Care. This accident is the subject of consolidated claim 11 WC 13698 decided separately in conjunction with this matter.

The records of Brookside Immediate and Occupational Care were admitted as Petitioner's Exhibit 5. Petitioner was first seen on April 6, 2010 with complaints of right shoulder pain. She stated she was lifting a resident at work when she felt a sharp twinge and pain in her right shoulder. The injury happened almost a month ago. She also complained of numbness and tingling radiating down from her shoulder into her right upper extremity. The impression was right shoulder pain, likely related to work. X-ray of the right shoulder was basically negative. Petitioner was prescribed medication, and placed on a 10-20 pound lifting restriction and advised to avoid above shoulder height reaching with the right arm (PX 5).

Petitioner was seen on April 15, 2010 and April 20, 2010 with a diagnosis of improving shoulder sprain. She reported doing a lot better by April 20, 2010. She had no significant tenderness and range of motion was fairly within normal limits. She was returned to full duty work on April 20, 2010 and advised to follow up in a week (PX 5). Petitioner testified that she was scheduled for follow up on April 27, 2010, but did not do so because she felt better. She testified that she was not 100%.

Petitioner testified that on October 18, 2010, she lifted a resident with a Hoyer and the equipment was locked. Respondent admitted Respondent's Exhibit 2 as the accident reporting of this incident. Petitioner testified she had to physically stop the patient from falling. She testified she felt pain in her breast and right shoulder. It was the same pain but it was just a little sharper. Petitioner testified she did not receive any medical attention for this. She felt better and was able to work full duty. This accident is the subject of consolidated claim 11 WC 24778 decided separately in conjunction with this matter.

Petitioner testified that between this second incident and March, 2011, her shoulder got worse. Petitioner identified Petitioner's Exhibit 2 entitled Winnebago County Injury/accident report. She testified she had another injury on March 14, 2011. She was getting ready to roll a patient when she felt pain in her right shoulder. It was a sharp pain, worse that before but similar to the original pain from the previous dates. Petitioner testified

she told her supervisor Debbie Miller and the charge nurse Debbie Halsted what happened. She also told Linda Hauser in Human Resources. Debbie Halsted gave her the forms to fill out. Petitioner testified she went to Physicians Immediate Care for medical treatment. She testified she was instructed to go there by Debbie Miller.

Linda Hauser testified that she was the nursing coordinator for Respondent until she retired April 24, 2012. She did all the accident reports. Ms. Hauser identified RX 2 as the report turned in for an incident on March 17, 2010 and prepared by Petitioner. She identified RX 3 as a report completed on March 14, 2011. Petitioner filled out page 1. Petitioner did not say anything to her at the time. She did not recall Petitioner telling her she had a new accident on that date. She did not ask Petitioner any questions about the March 14, 2011 document.

The records of Physicians Immediate Care were admitted as Petitioner's Exhibit 6. Petitioner was initially seen on March 16, 2011. She reported a shoulder injury in March, 2010. She was complaining of numbness and tingling to the hand, right worse, and pain in the shoulder. She feels the shoulder is aggravated and is progressively worsening. She rated the pain as 9/10. She denied any non work related activities that could contribute to her complaints. X-rays were normal. The glenohumeral joint is without degenerative changes. Petitioner received an injection. She had full range of shoulder motion after the injection Petitioner was given wrist splints and exercises. She was placed on restrictions of no overhead lifting or lifting over 15 pounds with the right arm. The record notes that her job would not justify a carpal tunnel diagnosis. The symptoms are radiating from the shoulder, likely due to the initial injury in 2010 and it was re-aggravated (PX 6).

Petitioner testified that she does not know why the records show the date of onset was February 20, 2011. She was placed on light duty work restrictions. She last saw Physicians Immediate Care on April 6, 2011 because she was feeling better.

Petitioner testified that she began treatment at Rockford Orthopedics at the suggestion of her medical doctor Dr. Deguzman at St. Anthony Medical Center. Petitioner saw Dr. Deguzman on April 5, 2011 for follow up. The history notes no complaints. The assessment notes Petitioner was seen for shoulder pain and high blood pressure (PX 7). Petitioner underwent an MRI of the right shoulder on April 23, 2011. The MRI impression was partial thickness tear distal supraspinatus and infraspinatus tendons and mild to moderate degenerative changes in the AC joint (PX 7, PX 10). Petitioner did not treat with Rockford Orthopedics because of the denial of her claim (PX 7, PX 4).

Petitioner testified that she sought treatment from Dr. Tingle at Northwest Orthopedic Surgery beginning July 5, 2011. Petitioner filled out a history of right shoulder problems since March 14, 2011. She reported the problem started when she lifted and rolled her resident. Dr. Tingle's July 11, 2011 chart note includes a history of three injuries. The initial injury occurred in 2010. The second injury occurred when a Hoyer lift locked up. The most recent injury occurred on March 14, 2011 when moving or lifting a patient. Following his examination, his impression was work–related right shoulder high grade partial thickness tear. Dr. Tingle states that given her ongoing symptoms of recurrence of her problem since it initially started in 2010, she is a candidate for surgery (PX 10). Petitioner was given light duty restrictions of no more than 10 pounds lifting and carrying on July 21, 2011 (PX 10). Petitioner testified she did not return to work with restrictions. Respondent required her to come back without restrictions.

Petitioner underwent surgery on August 15, 2011 consisting of a right shoulder diagnostic arthroscopy, debridement of the labrum and synovium, micro fracture of the humeral head, removal of loose bodies,

arthroscopic rotator cuff repair and subacromial decompression. Petitioner was taken off work effective August 15, 2011 (PX 10). Petitioner had post operative care and physical therapy August 17, 2011 through December 15, 2011 (PX 8). On November 16, 2011, Petitioner was released to restricted work of no lifting or carrying with her right arm over 10 pounds effective November 21, 2011 (PX 10). Petitioner testified she was not able to return to work at that time. Petitioner's work capacity was increased to 20 pounds with no overhead lifting on December 14, 2011. On January 10, 2012, Dr. Tingle's office was advised that Petitioner was terminated effective December 31, 2011 (PX 10). Petitioner testified she was terminated due to the FMLA period expiring. Petitioner was released from Dr. Tingle to return as needed on February 13, 2012 with permanent restrictions of no lifting more than 50 pounds with the right arm (PX 10). Petitioner testified that Respondent did not accommodate the restriction. Petitioner testified she began looking for work and found employment within a week at about the same money as she made as a CNA. She is now making more money than she was making as a CNA. She has continued working. Petitioner testified she returned to Dr. Tingle in October, 2012 for unrelated complaints. She did not receive any treatment for her shoulder.

Petitioner testified that she currently notes that her right shoulder is painful. It aches. If she overdoes it, she will still get pain. She notices pain doing household chores including laundry, groceries, yard work.

Dr. Stephen Weiss performed a record review at Respondent's request (RX 1). He notes that the records record an injury in March, 2010. The initial medical care was on April 6, 2010 and noted right shoulder pain, tenderness and decreased motion, but negative impingement signs. Within a week the examination was essentially normal except for mild tenderness and within two weeks she had a normal examination and was returned to full work. He then notes the care at Physicians Immediate Care beginning March, 2011 and Dr. Tingle beginning July 5, 2011 through her surgery and August 24, 2011 postoperative visit. Dr. Weiss diagnosed a resolved shoulder strain as of April 20, 2010. He opined that treatment after April 20, 2010 was not related to the March 17, 2010 incident. Based upon the lack of any specific accident being mentioned in the Physicians Immediate Care records, he opined that the operative findings were not causally related to any work exposure. On October 21, 2011, Dr. Weiss authored an additional report opining that the October 18, 2010 incident did not cause the need for surgery, the operative findings or the treatment after March 14, 2011 (RX 1).

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

The claimant in a Workers' Compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. Included within that burden is proof that she sustained accidental injuries and that her current condition of ill-being is causally connected to a work-related injury. Petitioner is alleging that her condition of ill being in the right shoulder and the treatment beginning on March 16, 2011 is the result on an accidental injury occurring on March 14, 2011. Respondent has denied that Petitioner suffered an accidental injury arising out and in the course of her employment on that date.

Petitioner testified to an initial March 17, 2010 injury to her right shoulder and provided a specific report of a work accident to Respondent. She received treatment at that time and was diagnosed with a sprain. She testified she was not 100% after that injury, but continued to work full duty as a CNA. She testified to a second

accident to the right shoulder on October 18, 2010 where the pain as the initial March, 2010 injury was the same only slightly sharper. Her reporting at that time was again of a specific injury on that date.

Petitioner testified that between this second incident and March, 2011, her shoulder got worse. On March 14, 2011, she was getting ready to roll a patient when she felt pain in her right shoulder. It was a sharp pain, worse that before but similar to the original pain from the previous dates. She did not testify to any other activity precipitating her symptoms. As opposed to the previous injury reports, Petitioner did not describe a specific injury, but rather referenced her prior March 17, 2010 work accident. The report lists this as the original date and the description of the accident mirrors the original March 17, 2010 accident report. She notes that the symptoms are now out of dormant, while stating that they never left. Her subsequent appeal of the denial of her claim was drafted after she had already retained counsel and filed her claims. The Arbitrator notes that even in this May, 2011 exchange of correspondence with Respondent, Petitioner fails to describe any specific mechanism of injury that occurred on March 14, 2011.

Her history to Physicians Immediate Care is similarly devoid on any claim of a new injury. She reported a shoulder injury in March, 2010. She was complaining of numbness and tingling to the hand, right worse, and pain in the shoulder. She feels the shoulder is aggravated and is progressively worsening. At no time during her treatment at Physicians Immediate Care does she describe a specific injury on March 14, 2011. Based upon this lack of any specific accident being mentioned in the Physicians Immediate Care records, Dr. Weiss opined that the operative findings were not causally related to any work exposure. The description of accident when moving or lifting a patient does not appear until Dr. Tingle's July 11, 2011 notes, well after this matter was in litigation. Based upon the evidence submitted, the Arbitrator finds that Petitioner has failed to sustain her burden of proving an accidental injury occurred on March 14, 2011.

Although Petitioner presented this matter claiming a specific accident on March 14, 2011, she also presented testimony concerning the job duties of a CNA and testimony concerning the understaffing of Respondent during the relevant timeframe. Such evidence could suggest a theory of repetitive trauma. However, there was no evidence presented as to the number of times that the various physical activities were performed or detail as to the forces required. Nor was any medical opinion offered to support such a theory.

In repetitive trauma cases, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. Although medical testimony as to causation is not required in every workers' compensation case, where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, "expert testimony is necessary to show that claimant's work activities caused the condition complained of. Cases involving aggravation of a preexisting condition primarily concern medical questions and not legal questions, and this is especially true in repetitive trauma cases. Thus, repetitive trauma claims involving the alleged aggravation of a preexisting condition, like the claim asserted here, cannot succeed unless the claimant presents medical evidence suggesting that (1) the claimant had a preexisting condition that was or could have been aggravated by her repetitive work activities, and (2) her current condition of ill-being was or could have been caused (at least in part) by this work-related trauma and is not simply the result of a normal, degenerative aging process. The only causation opinion offered was that of Dr. Weiss that the operative findings were not causally related to any work exposure.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an accidental injury arising out of and in the course of her employment on March 14, 2011.

In support of the Arbitrator's decision with respect to (E) Notice, (F) Causal Connection, (J) Medical, (K) Temporary Benefits, (L) Nature and Extent, and (N) Credit, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Accident, the issues of Notice, Causal Connection, Medical, Temporary Benefits, Nature and Extent, and Credit are moot. Petitioner's claim for compensation for the March 14, 2011 date of accident is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lavern Huggins,

Petitioner,

vs.

NO: 11WC 24778

River Bluff Nursing Home,

Respondent.

18IWCC0426

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of 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.

This matter was tried in conjunction with consolidated cases 11WC 13638 and 11WC 13639. However, Petitioner's Petition for Review filed December 22, 2016, on case 11WC 13638 was previously withdrawn and no decision will be issued at this time.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 1, 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.

18IWCC0426

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.

JUL 12 2018

DATED:
o071018
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUGGINS, LAVEREN
Employee/Petitioner

Case# **11WC024778**

11WC013638
11WC013639

RIVER BLUFF NURSING HOME
Employer/Respondent

18IWCC0426

On 12/1/2016, 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 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5511 DeCARLO LAW GROUP
ANITA M DeCARLO
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

0563 WILLIAMS & McCARTHY LLP
CAROL HARTLINE
120 W STATE ST SUITE 400
ROCKFORD, IL 61101

18IWCC0426

STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lavern Huggins
Employee/Petitioner

Case # **11** WC **24778**

v.

Consolidated cases: **11 WC 13638**
11 WC 13639

River Bluff Nursing Home
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **July 19, 2016 and October 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. [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. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **October 18, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$23,052.12**; the average weekly wage was **$443.31**.

On the date of accident, Petitioner was **51** years of age, *single* with **0** dependent children.

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

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

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

Respondent has paid benefits of **$23,651.80** under Section 8(j) of the Act for medical treatment to the right shoulder.

ORDER:

BECAUSE THE ARBITRATOR FINDS THAT PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HER CONDITION OF ILL BEING IN THE RIGHT SHOULDER IS CAUSALLY CONNECTED TO THE ACCIDENTAL INJURY SUSTAINED ON OCTOBER 18, 2010, THIS CLAIM FOR COMPENSATION IS HEREBY DENIED.

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

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

Signature of Arbitrator

December 1, 2016
Date

DEC 1 - 2016

Statement of Facts

This matter was tried in conjunction with consolidated cases 11 WC 13638 (date of accident March 17, 2010) and 11 WC 13639 (date of accident March 14, 2011). These matters were consolidated for hearing and a single transcript was prepared. The Arbitrator has issued separate decisions with respect to each of these claims.

Petitioner Lavern Huggins testified that she was employed by Respondent River Bluff Nursing Home as a certified nursing assistant since 2006. Respondent provides skilled care for geriatric patients. Petitioner testified her duties included bathing the residents. She would transfer them to the shower using a gait belt. If she needed to clean them outside of the shower, she would use a basin and water. She would turn and roll the resident. Most of the time there would be two people to do this. She used Hoyer lifts to move and lift the residents. Petitioner testified there are three wings to the home. There are 12 to 14 residents to one CNA. There are 3 CNAs when the shift is properly staffed. In early 2010, they were not fully staffed. There were one or two CNAs.

Petitioner testified that on March 17, 2010, she was lifting a resident with another person and started having weakness and pain in her right shoulder. Petitioner identified Petitioner's Exhibit 1 as the reporting she prepared at that time. She sought treatment at Brookside Immediate and Occupational Care. This accident is the subject of consolidated claim 11 WC 13698 decided separately in conjunction with this matter.

The records of Brookside Immediate and Occupational Care were admitted as Petitioner's Exhibit 5. Petitioner was first seen on April 6, 2010 with complaints of right shoulder pain. She stated she was lifting a resident at work when she felt a sharp twinge and pain in her right shoulder. The injury happened almost a month ago. She also complained of numbness and tingling radiating down from her shoulder into her right upper extremity. The impression was right shoulder pain, likely related to work. X-ray of the right shoulder was basically negative. Petitioner was prescribed medication, and placed on a 10-20 pound lifting restriction and advised to avoid above shoulder height reaching with the right arm (PX 5).

Petitioner was seen on April 15, 2010 and April 20, 2010 with a diagnosis of improving shoulder sprain. She reported doing a lot better by April 20, 2010. She had no significant tenderness and range of motion was fairly within normal limits. She was returned to full duty work on April 20, 2010 and advised to follow up in a week (PX 5). Petitioner testified that she was scheduled for follow up on April 27, 2010, but did not do so because she felt better. She testified that she was not 100%.

Petitioner testified that on October 18, 2010, she lifted a resident with a Hoyer and the equipment was locked. Respondent admitted Respondent's Exhibit 2 as the accident reporting of this incident. Petitioner testified she had to physically stop the patient from falling. She testified she felt pain in her breast and right shoulder. It was the same pain but it was just a little sharper. Petitioner testified she did not receive any medical attention for this. She felt better and was able to work full duty.

Petitioner testified that between this second incident and March, 2011, her shoulder got worse. Petitioner identified Petitioner's Exhibit 2 entitled Winnebago County Injury/accident report. She testified she had another injury on March 14, 2011. She was getting ready to roll a patient when she felt pain in her right shoulder. It was a sharp pain, worse that before but similar to the original pain from the previous dates. Petitioner testified she told her supervisor Debbie Miller and the charge nurse Debbie Halsted what happened. She also told

Linda Hauser in Human Resources. Debbie Halsted gave her the forms to fill out. Petitioner testified she went to Physicians Immediate Care for medical treatment. She testified she was instructed to go there by Debbie Miller. This alleged accident is the subject of consolidated claim 11 WC 13639 decided separately in conjunction with this matter.

Linda Hauser testified that she was the nursing coordinator for Respondent until she retired April 24, 2012. She did all the accident reports. Ms. Hauser identified RX 2 as the report turned in for an incident on March 17, 2010 and prepared by Petitioner. She identified RX 3 as a report completed on March 14, 2011. Petitioner filled out page 1. Petitioner did not say anything to her at the time. She did not recall Petitioner telling her she had a new accident on that date. She did not ask Petitioner any questions about the March 14, 2011 document.

The records of Physicians Immediate Care were admitted as Petitioner's Exhibit 6. Petitioner was initially seen on March 16, 2011. She reported a shoulder injury in March, 2010. She was complaining of numbness and tingling to the hand, right worse, and pain in the shoulder. She feels the shoulder is aggravated and is progressively worsening. She rated the pain as 9/10. She denied any non work related activities that could contribute to her complaints. X-rays were normal. The glenohumeral joint is without degenerative changes. Petitioner received an injection. She had full range of shoulder motion after the injection Petitioner was given wrist splints and exercises. She was placed on restrictions of no overhead lifting or lifting over 15 pounds with the right arm. The record notes that her job would not justify a carpal tunnel diagnosis. The symptoms are radiating from the shoulder, likely due to the initial injury in 2010 and it was re-aggravated (PX 6).

Petitioner testified that she does not know why the records show the date of onset was February 20, 2011. She was placed on light duty work restrictions. She last saw Physicians Immediate Care on April 6, 2011 because she was feeling better.

Petitioner testified that she began treatment at Rockford Orthopedics at the suggestion of her medical doctor Dr. Deguzman at St. Anthony Medical Center. Petitioner saw Dr. Deguzman on April 5, 2011 for follow up. The history notes no complaints. The assessment notes Petitioner was seen for shoulder pain and high blood pressure (PX 7). Petitioner underwent an MRI of the right shoulder on April 23, 2011. The MRI impression was partial thickness tear distal supraspinatus and infraspinatus tendons and mild to moderate degenerative changes in the AC joint (PX 7, PX 10). Petitioner did not treat with Rockford Orthopedics because of the denial of her claim (PX 7, PX 4).

Petitioner testified that she sought treatment from Dr. Tingle at Northwest Orthopedic Surgery beginning July 5, 2011. Petitioner filled out a history of right shoulder problems since March 14, 2011. She reported the problem started when she lifted and rolled her resident. Dr. Tingle's July 11, 2011 chart note includes a history of three injuries. The initial injury occurred in 2010. The second injury occurred when a Hoyer lift locked up. The most recent injury occurred on March 14, 2011 when moving or lifting a patient. Following his examination, his impression was work–related right shoulder high grade partial thickness tear. Dr. Tingle states that given her ongoing symptoms of recurrence of her problem since it initially started in 2010, she is a candidate for surgery (PX 10). Petitioner was given light duty restrictions of no more than 10 pounds lifting and carrying on July 21, 2011 (PX 10). Petitioner testified she did not return to work with restrictions. Respondent required her to come back without restrictions.

Petitioner underwent surgery on August 15, 2011 consisting of a right shoulder diagnostic arthroscopy, debridement of the labrum and synovium, micro fracture of the humeral head, removal of loose bodies,

arthroscopic rotator cuff repair and subacromial decompression. Petitioner was taken off work effective August 15, 2011 (PX 10). Petitioner had post operative care and physical therapy from August 17, 2011 through December 15, 2011 (PX 8). On November 16, 2011, Petitioner was released to restricted work of no lifting or carrying with her right arm over 10 pounds effective November 21, 2011 (PX 10). Petitioner testified she was not able to return to work at that time. Petitioner's work capacity was increased to 20 pounds with no overhead lifting on December 14, 2011. On January 10, 2012, Dr. Tingle's office was advised that Petitioner was terminated effective December 31, 2011 (PX 10). Petitioner testified she was terminated due to the FMLA period expiring. Petitioner was released from Dr. Tingle to return as needed on February 13, 2012 with permanent restrictions of no lifting more than 50 pounds with the right arm (PX 10). Petitioner testified that Respondent did not accommodate the restriction. Petitioner testified she began looking for work and found employment within a week at about the same money as she made as a CNA. She is now making more money than she was making as a CNA. She has continued working. Petitioner testified she returned to Dr. Tingle in October, 2012 for unrelated complaints. She did not receive any treatment for her shoulder.

Petitioner testified that she currently notes that her right shoulder is painful. It aches. If she overdoes it, she will still get pain. She notices pain doing household chores including laundry, groceries, yard work.

Dr. Stephen Weiss performed a record review at Respondent's request (RX 1). He notes that the records document an injury in March, 2010. The initial medical care was on April 6, 2010 and noted right shoulder pain, tenderness and decreased motion, but negative impingement signs. Within a week, the examination was essentially normal except for mild tenderness and within two weeks she had a normal examination and was returned to full duty work. He then notes the care at Physicians Immediate Care beginning March, 2011 and Dr. Tingle beginning July 5, 2011 through her surgery and an August 24, 2011 postoperative visit. Dr. Weiss diagnosed a resolved shoulder strain as of April 20, 2010. He opined that treatment after April 20, 2010 was not related to the March 17, 2010 incident. Based upon the lack of any specific accident being mentioned in the Physicians Immediate Care records, he opined that the operative findings were not causally related to any work exposure. On October 21, 2011, Dr. Weiss authored an additional report opining that the October 18, 2010 incident did not cause the need for surgery, the operative findings or the treatment after March 14, 2011 (RX 1).

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

The parties stipulated that Petitioner sustained accidental injuries on October 18, 2010. RX 4 confirms that Petitioner reported the Hoyer wheels locked which caused minor pain to Petitioner's breast area and right shoulder. Petitioner testified that she sought no medical treatment. RX 4 confirms that no first aid or medical was sought. When Petitioner sought care on March 16, 2011, the October 18, 2010 accident was not mentioned in the history. The "Assessment" was rotator cuff strain. The comment was that it is possibly due to the original March, 2010 injury and it was re-aggravated. Petitioner's handwritten history to Dr. Tingle notes symptoms since March 14, 2010. While the history taken in his July 5, 2011 office note references all three accident dates testified to by Petitioner, he provides no specific causation opinion. His August 8, 2011 assessment is status post multiple work-related injuries. Dr. Weiss, in his October 21, 2011 note specifically opines that the October 18, 2010 incident could not have caused any of the treatment undertaken after March 14, 2011.

A Workers' Compensation claimant bears the burden of showing by a preponderance of credible evidence that her current condition of ill-being is causally related to the workplace injury. Petitioner testified that she was not 100% after the March 17, 2010 injury. She testified that the pain that she felt in October, 2010 was the same as in March, 2010 just sharper. She testified that she felt better thereafter and was able to work full duty. She continued to work without seeking treatment until March, 2011, a gap in care of five months. The Commission has consistently considered such gaps in treatment in determining whether subsequent medical care is causally connected to the injury. See *Richard Olcikas v. Dominick's Finer Foods*, Inc., 2009 Ill. Wrk. Comp. LEXIS 1098; *Jacob Haltom v. Center for Sleep Medicine*, 2013 Ill. Wrk. Comp. LEXIS 509; 13 IWCC 563; *Jose Ruben Meraz vs. Minute Men Staffing*, 2015 Ill. Wrk. Comp. LEXIS 30; 15 IWCC 30. Based upon the evidence submitted, the Arbitrator finds the opinion of Dr. Weiss that the October 18, 2010 incident could not have caused any of the treatment undertaken after March 14, 2011 persuasive.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove that the condition of ill being in her right shoulder is causally connected to the accidental injury sustained on October 18, 2010.

In support of the Arbitrator's decision with respect to (J) Medical, (L) Nature and Extent, and (N) Credit, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection above, the remaining issues of Medical, Nature and Extent and Credit are moot.

The claim for compensation for the accident date of October 18, 2010 is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CRAIG TAYLOR,

Petitioner,

18IWCC0427

vs. NO: 16 WC 17052

STATE OF ILLINOIS – DEPARTMENT OF TRANSPORTATION,

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, permanent partial disability, and medical expenses, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner sustained his burden of proving a compensable accident on May 3, 2016. Because the Commission remands the instant cause for determination of an award of appropriate benefits, the Commission will only address the issue of accident

Findings of Fact & Conclusions of Law

1. Petitioner testified he worked for Respondent as a vehicle compliance inspector. On May 3, 2016 he was doing paperwork at Respondent's Carlyle facility. He identified an exhibit as photographs of the location on which he fell. It shows parking blocks, one of which he tripped over. Petitioner agreed that on that day, he arrived at the facility, did his paperwork, picked up his computer, and left the building.

2. As he left the building he saw Mr. Hemann, a traveling mechanic for Central Management Services ("CMS"). Petitioner checked his inspection reports. Petitioner greeted Mr. Hemann and asked if he had everything he needed, as he did with other traveling CMS mechanics. Mr. Hemann was getting in a heavy-duty, 1-ton, van, and getting ready to leave. Petitioner was looking forward carrying his laptop in his right hand.

3. Mr. Hemann started his vehicle, while Petitioner was in very close proximity, which "kind of startled" him. He turned around in front of Mr. Heman's vehicle, his foot hooked on the parking block, and he fell down. He was not able to see the block because of Mr. Hemann's vehicle.

4. Petitioner showed the Arbitrator a photograph on his phone of the block he fell over. Petitioner described it as showing "the sharpness of the concrete because most of them are rounded." It showed a mark where his boot struck the block. He related a previous incident in which a bus started up next to him and actually drove over his foot. Since that incident, he gets scared when a vehicle starts in his proximity. Petitioner landed on his "right hand, it spun under," and his knuckles were cut up with concrete marks. He hurt his right leg, right arm, and right shoulder. Everything except his shoulder healed and was fine.

5. Petitioner also testified that before his instant accident Petitioner's shoulder was good. After the accident, his shoulder hurt, but it improved with surgery by Dr. Mall and postoperative physical therapy. He has a little bit of soreness when he drives for longer periods of time. Dr. Mall advised him to use both arms doing things and to be careful not to do anything overhead or too far in front of himself. He no longer "rocks the [steering] wheel," which is a test of the steering mechanism, to avoid additional injury. He has difficulty doing his own maintenance work. He occasionally uses over-the-counter pain medication, "if it's a long day."

6. On cross examination, Petitioner agreed that Dr. Mall released him on December 30, 2016, and indicated he had made a full recovery. He had excellent functionality, due to the excellent physical therapy "ladies." He has returned to full duty, but he does not do all of the work activities he did prior to the accident and does more paperwork. Petitioner disagreed that a particular exhibit accurately showed the parking block at the time of the accident. The vehicle's bumper was "right close to the edge of the block itself."

7. Petitioner also testified that he was on the driver's side of the vehicle and it was on the right "making the parking block exposed to the driver's side of the vehicle." The "block was about 18 inches to the left of the driver's side door." The bumper was "almost at the edge of the parking block." There was not much space between the bumper and the block. He agreed that the block was not defective.

8. Petitioner also testified that the lot was new construction, but he had used it before; he goes there once a week. He estimated he had been in the lot 15 times in the six months prior to the accident. He agreed that he had shoulder surgery about 10 years prior to the accident. His latest surgery was his third on the right rotator cuff.

9. On redirect examination, Petitioner agreed he was right in front of the van when Mr. Hemann "fired up the big engine," which startled him and caused him to twist and hook his foot.

The Arbitrator found that Petitioner did not sustain his burden of proving he sustained an accident that arose out of his employment. She concluded that the risk of tripping was not a risk associated with his employment, the parking lot was not defective in any way, and it was like any other parking lot that members of the public encounter every day *i.e.* in malls *etc.* In addition, she discounted Petitioner's testimony that he was carrying the laptop at the time of the accident. She noted that he did not testify that he used the laptop in his work or that it contributed to his fall. She emphasized that if carrying the computer contributed to his fall, he would have included that fact in his report, which he did not.

Petitioner argues that the Arbitrator erred in not finding accident. He asserts, apparently for the first time on review, that Petitioner was a traveling employee and that his activities and his fall were reasonably foreseeable. He cites *Nee v. IWCC*, 28 N.E.3d 961 (1st Dist. WC div. 2015), in which the Appellate Court found that a City of Chicago plumbing inspector was a traveling employee under the Act. Respondent responds that Petitioner was not a traveling employee and stresses that Petitioner was injured on Respondent's premises, while the claimant in *Nee* was at a remote inspection site.

First, the Commission concludes Petitioner did not sustain his burden of proving that he was a traveling employee. Petitioner really did not testify at all about his work activities, if he indeed traveled on behalf of Respondent in the course of his employment, and if so the percentage of his work time was spent traveling on behalf of Respondent.

Nevertheless, although Petitioner did not prove he was a traveling employee, the Commission finds that he did prove he sustained a compensable accident. Petitioner testified he was holding a laptop at the time of the accident. Petitioner testified that he always interacted with traveling CMS mechanics as part of his employment. The Commission concludes that Petitioner's approaching Mr. Hemann and conversing with him placed him in some greater risk of sustaining injury. Petitioner's work activities requiring him to approach Mr. Hemann's vehicle not only brought him in proximity to the parking block while the vehicle was obstructing the view of the block, the work activities may have caused a distraction that members of the general public using the parking lot would not have experienced. Therefore, the Commission concludes that Petitioner's employment activities placed him at greater risk of sustaining injury in the public parking lot.

While the Commission finds Petitioner proved a compensable accident, we decline to award benefits on review. The Arbitrator declined to specifically address an appropriate award because under her decision the issue of benefits was moot. The Commission believes the Arbitrator would be in a better position than the Commission to determine an appropriate award of medical expenses, temporary total disability, and most notably permanent partial disability. In addition, after the Commission has finally determined compensability, the parties can hopefully come to an agreement regarding at least some of the outstanding issues such as medical expenses and temporary total disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated April 17, 2017 is hereby reversed.

18IWCC0427

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner has sustained his burden of proving he sustained a compensable accident on May 3, 2016.

IT IS FURTHER ORDERED BY THE COMMISSION that the matter be remanded to the Arbitrator for proceeding consistent with this decision to determine appropriate benefits arising from the compensable accident on May 3, 2016.

DATED: JUL 12 2018

David L. Gore

DLS/dw
O-6/7/18
46

Stephen J. Mathis

Dissent

I respectively dissent from the Decision of the majority. I would have affirmed and adopted the Decision of the Arbitrator and denied compensation. I agree with the analysis of the Arbitrator and her findings that the risk of tripping was not a risk associated with Petitioner's employment, the parking lot was not defective in any way, and that the lot was like any other parking lot that members of the public encounter every day *i.e.* in malls *etc.* For these reasons, I respectively dissent.

DLS/dw

Deborah L. Simpson

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VICKY JONAS,

Petitioner,

18IWCC0428

vs.

NO: 05 WC 42638

STATE OF ILLINOIS – PONTIAC CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues 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.

Findings of Fact & Conclusions of Law

1. Petitioner testified on April 14, 2005 she worked for Respondent as a licensed practical nurse. On that day, she had to deliver insulin. She had to open "really big gates" which did not open automatically. As she pushed it open "something snapped in" her back and she felt pain. She reported the accident and obtained medical care.

2. Initially, she saw her primary care physician, Dr. Long, whom she saw for about nine months. After he provided conservative treatment, including physical therapy, he referred her to Orthopedic Associates of Kankakee. There, she continued with conservative treatment for about five months. Thereafter, she was referred to Dr. Malek, a neurosurgeon. Petitioner's condition continued to worsen and in April of 2006 she had a fusion at L2-3 with instrumentation.

3. After about three weeks, Petitioner "underwent a re-exploration" of her surgical site. Dr. Malek referred Petitioner to Dr. Kelly for pain management. On June 2, 2008, she had a temporary pain pump implanted, which was replaced by a permanent one in August of 2008. It was still implanted at the time of arbitration. Petitioner continued to treat with Dr. Kelly for the last 10 years. Injections and a stimulator did not help but the pain pump did provide some relief, though she was never pain free. Dr. Kelly monitors the pain medication infused by the pump. Petitioner has been off work since the accident. Additional surgery had been discussed. Petitioner was told that surgery could lead to her being wheelchair-bound for the rest of her life. She declined the surgery.

4. At Respondent's request, Petitioner saw doctors for Section 12 examinations. She saw Dr. Kornblatt on September 17, 2007 and she saw Dr. Patel on July 29, 2014. In December of 2015, Respondent also sent her to a voc rehab counselor, Ms. Helen Weber. They commenced a job search, which Petitioner still continues. She is required to submit a certain number of applications a week. She has submitted almost all of her applications on line. She had not yet received any interviews. She currently has a five-pound lifting restriction, with no excessive bending/stooping/reaching. Probably less than 10% of the jobs she applied for are actually within her restrictions. She then estimated that maybe about 3% are within her restrictions.

5. Petitioner was currently 59 years old. She has a GED, completed a CNA course, and became licensed as a practical nurse in 1989. Her LPN was kept open for 10 years, but she was unable to maintain the requirements. Currently, she has swelling in her legs, with throbbing, cramping, and stabbing pain while walking. She also has lumbar pain. Her pain ranges between 6/10 on a good day and 10/10 on a bad day. She had maybe two good days a week. She takes Percocet for break-through pain. She can walk about 30 minutes or stand about one hour before her pain increases. She has numbness down her right leg, almost every day.

6. Petitioner also testified that her 34-year-old daughter moved in with her and her husband two years previously. Petitioner has hired a housekeeper every other weekend since 2006. Her daughter does the housework in the interim. Petitioner has probably not mopped since the accident. If she had a job, she would have to get up and walk around after sitting an hour, and then she would have to lie down. She never hurt her back or had any of these symptoms prior to the accident.

7. The medical records indicate that after the accident, Petitioner first presented to her primary care physician. She was diagnosed with lumbar strain, prescribed medications and physical therapy, and taken off work.

8. Petitioner was referred to Dr. Santiago. She complained of 9/10 low back pain radiating into the left leg. Dr. Santiago diagnosed lumbar radiculopathy, refilled medications, kept her off work, and ordered an MRI. It was taken on June 5, 2005 and showed a broad-based bulge at L2-3 slightly deforming the ventral subarachnoid space with no root compression or canal stenosis, and multilevel arthropathy/arthrosis.

9. On June 9, 2005, Petitioner returned to Dr. Santiago. She continued to complain of low back pain radiating into the left leg. Dr. Santiago noted that the MRI did not show clear evidence of nerve root compression and therefore, her pain might be discogenic in nature. He noted an epidural steroid injection was indicated. Depending on her response, he might consider a CT.

10. On August 4, 2005, after he administered two epidural steroid injections, Dr. Santiago now noted that the MRI showed a broad-based superficial bulge at L2-3 and mild degenerative disc disease throughout the lumbar spine. She had two-days of relief from the second injection. Her pain currently went to her ankle. She was taking Darvocet and Flexeril. Dr. Santiago felt conservative treatment was exhausted and referred Petitioner to Dr. Malek for a second opinion.

11. Petitioner presented to Dr. Malek on August 17, 2005 for evaluation of back/leg pain, of equal severity, though worsening. She had physical therapy and injections, without significant relief. Her gait was antalgic and straight leg raise was positive on the right. The MRI showed multi-level desiccation and possible herniation on the right at L5-S1. Dr. Malek recommended an EMG and CT/myelogram. Later, Dr. Malek noted that the EMG was negative, and he could not tell whether there was evidence of a disc herniation. He ordered a discogram L2-S1. Dr. Malek noted the discogram was positive at L2-3. They discussed possible fusion. He would set her up with a second opinion.

12. On January 30, 2006, Petitioner returned to Dr. Malek after seeing Dr. DePhillips, who indicated that if the condition was bothering her sufficiently, it would not be unreasonable to consider a fusion or IDET. Petitioner preferred the more definitive fusion. Dr. Malek wanted an additional discogram prior to surgery to determine whether other levels should be addressed.

13. On April 3, 2006, Dr. Malek performed bilateral laminectomy with discectomy and decompression, nerve root decompression and foraminectomy at L2, bilateral discectomy at L2-3, posterior right-sided interbody graft with cage at L2-3, and "posterior segmented anterior fixation" with screws bilaterally at L2-3 for segmented instability at L2-3 incapacitating symptoms unresponsive to conservative treatment. However, it was noted that no instability was found in the surgery.

14. On April 21, 2006, Dr. Malek performed exploration of the wound and fusion and found excellent fusion, excellent placement, and no foraminal narrowing.

15. On August 4, 2006, Petitioner presented to Dr. Kelly on referral from Dr. Malek for chronic (4-10/10) back pain. The pain had been constant since her reported work accident. The pain persisted despite treatment including fusion surgery, though she reported the leg pain was more severe preop. Currently, low back pain was her main complaint and was using a TENS unit, without significant relief. She had also taken Darvocet and Oxycodone without benefit and was currently taking Valium and using a Fentanyl patch. Dr. Kelly diagnosed bilateral sacroiliitis and arachnoiditis, possible neuropathic back/right leg pain. He recommended bilateral SI joint injections.

16. On September 6, 2006, Petitioner reported significant relief from the SI injections, but it lasted only a few days. The pain returned and was at 8-9/10. Dr. Kelly diagnosed "postlaminectomy syndrome with pain in the basis of chronic nerve damage." He believed there was a component of axial mechanical pain likely due to SI arthropathy, improved on the left and more persistent on the right. He adjusted medication and provided her information on spinal cord stimulators.

17. At Respondent's request, on September 17, 2007 Petitioner presented to Dr. Kornblatt for an examination under Section 12 of the Act. After his review and summarization of Petitioner's medical treatment and his clinical examination, Dr. Kornblatt opined that Petitioner suffered a work injury which resulted in a lumbosacral strain and aggravation of preexisting lumbar degenerative disc disease and facet arthritis. The surgery was performed for chronic pain caused by the lumbosacral strain. She did not get relief from L2-3 fusion surgery, but rather developed chronic pain dysfunction and failed back surgery syndrome. She might need to have the hardware removed, but a spinal cord stimulator was not indicated. Presently, Petitioner was totally disabled.

18. On July 2, 2008, Petitioner returned to Dr. Kelly and reported 8-10/10 pain. Dr. Kelly refilled medications set up for a trial of intrathecal catheter for trial of intrathecal narcotics. Dr. Kelly continued to treat Petitioner with injections, medication, and the implantation of a trial spinal cord stimulator, which was considered failed.

19. On August 11, 2008, Dr. Kelly performed inpatient implantation of a programmable intrathecal pump and intrathecal catheter for failed back surgery syndrome. Petitioner returned to Dr. Kelly on numerous occasions thereafter and he would refill the pump and adjust dosage. The last such entry appears to be on August 8, 2016.

20. In August of 2014, Petitioner presented to Dr. Patel for another examination under Section 12. Dr. Patel noted that Petitioner presented using a 4-point cane, walking with an antalgic gait, and complaining mostly of back and right-leg pain. He reported her accident and medical treatment to date. She rated her pain as normally at 6/10, currently at 8/10, and worst at 10/10. The pain radiated down the right thigh, "somewhat diffusely." She reported she could stand for about 30 minutes and sit for about an hour. She reported no pain in her back or leg prior to the accident.

21. Dr. Patel opined that Petitioner sustained a lumbar sprain in the work-related accident. It did not respond to conservative treatment and she then had L2-3 fusion, which also did not provide any improvement. She had a pain pump, which at least allowed her to function. Currently, she had myofascial tenderness in the lumbar spine, which Dr. Patel attributed to deconditioning and normal accumulation of scar tissue postop. He opined that she suffered a lumbar sprain and surgery was performed. However, she exhibited non-dermatomal distribution of pain in the right leg and there was no significant nerve root entrapment in the imaging. He really was unsure of the source of her pain. Therefore, he could not rule out secondary gain as a cause for her pain.

22. Dr. Patel also noted that because of the chronic pain dysfunction, which necessitated the use of opioids for a long duration, she had significant central sensitization which heightened her pain perception and resulted in overall disability and dysfunction. He recommended stopping oral Percocet completely and reducing the narcotics in the pain pump. He recommended use of a nerve membrane stabilizer, such as Gabapentin or Lyrica. He did not believe she needed any additional treatment or evaluation. However, she would need work restrictions. He recommended an FCE, after which she would be at maximum medical improvement and be released to work based on the findings.

23. Petitioner submitted purported job search logs spanning from December 20, 2015 through September 17, 2016. It includes about 52 sheets comprising about 275 entries. All the entries indicate that the lead came from either Monster.Com or Indeed.Com. Results were reported as "none," "applied for," or "sent resume." The exhibit also includes responses from Indeed and Monster indicating that applications had been submitted, that applications were started and may or may not have been competed, or asking Petitioner for additional information or qualifications. There appears to 70 such responses. There was also a notation from Indeed.Com that she had applied for 60 positions and "saved" one. Some employers were named multiple times, and there certainly could be some duplications.

24. On April 1, 2016, a vocational rehabilitation counselor, Ms. Weber, reviewed Petitioner's job search logs. She noted that Petitioner documented 58 completed job applications to 46 individual employers, nine of which she applied multiple times. Ms. Weber noted that on average Petitioner applied for only 14 jobs per month, or about three a week. She opined that even allowing for a lull in the holiday season, Petitioner must devote more time to her jobs search activities. She noted 50 entries in which she was unable to verify the applications, with a few having no record of an application. Ms. Weber indicated that Petitioner could obtain employment within her restrictions and in her geographic area.

As noted above, the Arbitrator awarded Petitioner 300 weeks of permanent partial disability benefits representing loss of 60% of the person-as-a-whole. The Arbitrator cited a prior Commission decision in *Ballinger v. Montgomery Wards*, 98 I.W.C.C. 64402 (2007), as analogous to the instant claim. Respondent also cites *Ballinger* and seeks reduction of the award to loss of 40% of the person-as-a-whole.

In *Ballinger*, the claimant underwent a one-level cervical fusion, had physical therapy, treated at a pain clinic for several years, and was ultimately diagnosed with failed back syndrome and chronic pain. The claimant had not returned to work and the treating doctor declared him permanently disabled from employment. Nevertheless, the Commission found that the claimant was capable of sedentary work and awarded him loss of 50% of the person-as-a-whole. The Commission agrees with the Arbitrator that *Ballinger* is analogous to the instant claim. However, we see no reason to increase the award over that awarded in *Ballinger*. Accordingly, the Commission reduces the permanent partial disability award to 250 weeks representing loss of 50% of the person-as-a-whole.

18IWCC0428

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $475.13 per week for a period of 487&2/7 weeks, in temporary total disability benefits.

IT IS FURTHER ORDERED BY THE COMMMISSION that Respondent pay to Petitioner the sum of $475.13 per week for a period of 487&2/7 weeks, in maintenance benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is granted credit of $214,698.14 in temporary total disability and maintenance payments made.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $427.61 per week for a period of 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of 50% of the person-as-a-whole.

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

DATED: JUL 12 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-6/28/18
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0428

JONAS, VICKY
Employee/Petitioner

Case# **05WC042638**

ST OF IL/DEPT OF CORRECTION
Employer/Respondent

On 11/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% 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:

0575 REGAS GUBBINS & REGAS
MATTHEW T GUBBINS
ONE DEARBORN SQ SUITE 300
KANKAKEE, IL 60901

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

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

NOV 21 2017

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

18IWCC0428

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

- [ ] 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

Vicky Jonas
Employee/Petitioner

v.

State of Illinois/Dept. of Corrections
Employer/Respondent

Case # **05** WC **42638**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Peoria**, on **9/21/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0428

FINDINGS

On **4/14/05**, 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 **$34,589.00**; the average weekly wage was **$712.69**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$41,161.96** for TTD, **$0** for TPD, **$173,536.18** for maintenance, and **$0** for other benefits, for a total credit of **$214,698.14**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $475.13/week for 487 4/7 weeks, commencing 4/15/05 through 8/18/14, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $41,161.96 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner maintenance benefits of $475.13/week for 109 2/7 weeks, commencing 8/19/14 through 9/21/16, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $173,536.18 for maintenance benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $427.61/week for 300 weeks, because the injuries sustained caused the 60% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Michael K. Nowak, Arbitrator

10/19/17
Date

ICArbDec p 2

BACKGROUND

This is an accepted claim with the parties stipulating to accident and causation. The only issues in dispute are the nature and extent of Petitioner's disability and the amount due for TTD and/or maintenance. The parties stipulated and agreed that Respondent is entitled to credit of $214,698.14 for TTD and maintenance payments. AX1. It appears to the Arbitrator based upon Respondent's exhibit three that TTD was paid through July 2014 and maintenance was commenced August 1, 2014. Maintenance was last paid on May 15, 2016. RX3.

FINDINGS OF FACT

Petitioner, Vicky Jonas, was a licensed practical nurse employed by Respondent at Pontiac Correctional Center. On April 13, 2005, while at work and on-duty, Petitioner was pulling a heavy gate, which was stuck, and felt pain in her low back. Pain began radiating to her hips and thighs, she gave notice of this injury, and saw her primary care physician Dr. Jeffrey Long at the Medical Group of Kankakee County the next day. It was noted she was to be on vacation for the next week and one half, and she was instructed to return in 5 – 7 days if she was no better. PX1. One week later, Petitioner presented to Dr. Jeffrey Barra at the Medical Group of Kankakee County and she was diagnosed with a lumbar strain and prescribed physical therapy. Id. Petitioner was ordered off-work on 4/22/2005. Id.

Therapy did not improve her symptoms and she was referred to Dr. Juan Santiago-Palma at Orthopedic Associates of Kankakee who diagnosed her with left lumbosacral radiculopathy. PX3. An x-ray showed degenerative changes prominent at L1-L2 with fairly marked spurring, and less spurring at L1, L2, and L3. Id. An MRI showed a broad-based circumferential bulge at L2-L3. Id. Dr. Santiago-Palma performed steroid injections on 5/29/2005 and 6/29/2005. Id.

On 8/17/2005, Petitioner was seen by Dr. Michel Malek, a neurosurgeon, who performed a discogram, which implicated L2-L3 as the pain generator. PX4. Petitioner underwent L2-L3 posterior fusion on April 3, 2006. Id. Following the surgery, Petitioner had worsening of right leg pain and weakness, and underwent exploration of the fusion, which revealed excellent placement of plate and screws. PX5. This was performed on April 21, 2006. Id. She was prescribed PT, but only attended for one week due to pain.

Petitioner then saw Dr. James Kelly at Metro Area Pain Consultants on August 4, 2006, who recommended bilateral sacroiliac join injections, which she received on August 23. PX7. She was also evaluated by Dr. John Liu at Northwestern who recommended conservative treatment and no further surgery. Petitioner began PT at United Physical Therapy Services, but only attended for two weeks due to her high pain levels.

Dr. Kelly recommended a spinal cord stimulator to treat her new diagnosis of failed back syndrome. PX7. Petitioner submitted to her third EMG since the date of accident on 2/7/2007. PX7. The first two were normal, but the third showed lumbosacral radiculopathy at L5-S1. Id. Again she was prescribed physical therapy, and again was unable to complete the program due to pain. Id.

On April 13, 2007, she underwent a right L5-S1 injection, and did not report significant improvement.

On 8/13/2007, she received the spinal cord stimulator trial from Dr. Kelly. PX7. She did not report significant improvement, and the trial did not become permanent. Id.

On September 17, 2007, Petitioner presented to Dr. Michael Kornblatt for an examination pursuant to section 12 of the Act. PX8. Dr. Kornblatt reviewed her treatment history, her symptoms, her diagnostic tests, her medications, and performed a physical exam. Id. He opined that Petitioner suffered a lumbosacral strain and aggravation of a preexisting lumbar degenerative disc disease and facet arthritis as a result of her April 13, 2005 work accident. Id. He also opined that the accident necessitated surgery, which in turn resulted in "failed back surgery syndrome."

He noted "there may be some retropulsion of the posterior lumbar interbody fusion internal fixation device, which may be causing pain and disability. It is possible that the claimant may necessitate an anterior spinal procedure for removal of the interbody case and repair of the L2-3 interbody fusion." Id. He continues, "Presently, the claimant is totally disabled due to chronic pain dysfunction…[she] has yet to reach maximum medical improvement regarding the spinal surgery, which was performed April 13, 2006." Id.

Petitioner continued to report significant pain while seeing Drs. Kelly and Malek. PX4, PX7. An intrathecal implantable pain pump trial was performed on June 2,2008, this time with significant improvement of symptoms, and therefore the pump was permanently installed on August 11, 2008. PX7.

Petitioner returned to Dr. Malek on October 27, 2008, and he completed a work status report indicating "off-work" and wrote "permanent" on the same line. PX11. Petitioner continued to see Dr. Malek periodically until May 3, 2010, but no additional treatment other than monitoring was provided.

As of the date of hearing Petitioner remained under the care of Dr. Kelly on a regular basis for pain medicine refills, including her pain pump. PX7.

On August 18, 2014, Petitioner presented to Dr. Arpan Patel, a pain interventionalist and anesthesiologist, at Respondent's request pursuant to section 12 of the Act. RX1. He reviewed her treatment history, her symptoms, her diagnostic tests, and her medications. Id. At that time, she reported pain in her low back that radiates into her right buttock. Id. She reported 8/10 pain at the time of the exam, an average of 6/10 pain, and 10/10 pain at its worst. Id. He performed a physical exam. Id. He reviewed her work history and education. Id. He indicated he was "unsure as to the true nature of pain radiating into the right leg and cannot rule out secondary gain as a source of her complaints." Id. He also said long-term opioid usage has "heightened her perception of pain, and has resulted in her overall disability and dysfunction." Id. He recommended Petitioner cease the use of oral Percocet, as it offers only psychological relief, and reducing the overall opioids in her pain pump. Id. He opined Petitioner "will require some physical restrictions in order to perform work duties." Id. He indicated those restrictions could be determined following an FCE. He further noted 'A desk job type position with frequent stretching and moving capabilities would suffice. She may not be able to work a full eight-hour day." Id. No FCE was offered or performed.

Despite the opinion of Dr. Patel, Respondent did not provide vocational assistance. It appears from the record that on December 20, 2015 Petitioner began conducting a job search on her own. Petitioner's job search log was entered into evidence. PX12. It is unclear what, if any, actual vocational services or assistance were

provided to Petitioner. What is clear from the evidence in the record is that on April 1, 2016 Helen Weber, MS, CRC, of Creative Case Management, prepared a report in which she critiques Petitioner's job search log. The Arbitrator read and carefully considered her report. Ms. Weber noted that Petitioner had made 52 applications for work, with 46 individual employers, during the approximately 3 months prior to her report. The report indicates that a "reasonable individual" would to apply for more positions than Petitioner had. However, the report does not indicate what number of applications a "reasonable individual" should make in any given time period. Ms. Weber also pointed out that of the 52 applications mentioned in Petitioner's job log at the time she was unable confirm or refute that applications 35 of the applications were made because either the employers would not disclose information or no longer had records of applications. Her report further indicates that 7 of the employers had no record of Petitioner applying and that two of the employers had contacted Petitioner to schedule an interview but she failed to contact them to schedule. At trial Petitioner denied she was ever contacted for any interview. The report also points out that Petitioner applied to a number of employers more than once and that she applied for 4 positions that appeared to be either beyond her physical abilities or experience level. The Arbitrator notes that while she did apply to a number of employers more than once some of the applications were for different positions and with some the reapplications were spread over time. Petitioner testified that she was willing to attempt work beyond her restrictions in necessary. The Arbitrator notes there does not appear to have been any direction or suggestion given to Petitioner regarding the proper approach to making job search prior to Ms. Weber's critique of the job log.

It does not appear Ms. Weber ever passed any of her critiques on to Petitioner or offered any suggestion to improve the search. Petitioner testified that she became aware of Respondent's criticism of her job search and modified her search in order to make contacts more verifiable, which she appears to have done. PX12. Maintenance was last paid on May 15, 2016, but Petitioner's un successful job search continued through the date of hearing.

Petitioner did not submit evidence from a vocational professional.

CONCLUSIONS

The parties agree that Petitioner is not capable of returning to her former employment. The dispute concerns the period for which TTD is due and whether maintenance benefits are due at all.

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

There is no dispute that Petitioner was entitled to TTD immediately following the accident.

On October 27, 2008 Dr. Malek completed a work status report indicating "off-work" and wrote "permanent" on the same line. PX11. Petitioner continued to see Dr. Malek until May 3, 2010. As of the date of hearing Petitioner remained under the care of Dr. Kelly on a regular basis for pain medicine refills, including her pain pump. On August 18, 2014, Petitioner presented to Dr. Arpan Patel, at Respondent's request he opined Petitioner will require some physical restrictions in order to perform work duties, and that restrictions could be determined following an FCE. He further noted that she may not be able to work a full eight-hour day. No FCE was offered or performed. The Arbitrator finds Petitioner is entitled to TTD from the date of accident through August 18, 2014 when she was examined by Dr. Patel.

Despite the undisputed evidence that Petitioner could not return to her former employment, Respondent did not offer or provide vocational assistance. However, according to Respondent's payment records they began paying maintenance benefits on August 1, 2014. On December 20, 2015 Petitioner began conducting a job search on her own. Although perhaps less thorough than a job search conducted with professional guidance, Petitioner continued to perform her job search through the date of hearing. Further, when Respondent provided feedback regarding Petitioner's job search she modified her search as evidenced by PX12. In light of the fact that no professional vocational rehabilitation services were offered, as well as the record as a whole, The Arbitrator finds Petitioner's self directed job search was reasonable under the circumstances and that she is entitled to maintenance up to the date of hearing.

Respondent shall pay Petitioner temporary total disability benefits of $475.13/week for 487 4/7 weeks, commencing 4/15/05 through 8/18/14, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $41,161.96 for temporary total disability benefits that have been paid.

Respondent shall further pay Petitioner maintenance benefits of $475.13/week for 109 2/7 weeks, commencing 8/19/14 through 9/21/16, as provided in Section 8(a) of the Act. Respondent shall be given a credit of $173,536.18 for maintenance benefits that have been paid.

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

Petitioner seeks an award for permanent and total disability pursuant to Section 8(f) of the Act. In order to prove entitlement to an award of permanent and total disability benefits Petitioner must show: that by a preponderance of the medical evidence she is incapable of performing any work; that she is so handicapped that she will not be employed regularly in any well-known branch of the labor market; or that she has conducted a diligent but unsuccessful job search.

Dr. Malek completed a work status report on 10/27/2008 where he checked the box indicating "off-work" and wrote "permanent" on the same line. He also wrote "patient is permanently disabled." The next available treatment note from Dr. Malek is from 4/13/2009, where he writes "Restrictions are permanent" under the "Work Status" section. Dr. Patel states in his August 2014 IME that Petitioner "will require some physical restrictions in order to perform work duties." He further notes that restrictions may be set after Petitioner undergoes an FCE. He indicates that Petitioner could probably perform sedentary work, although she may not be able to work a full eight-hour work day. However, the Arbitrator finds that the somewhat cryptic notations of Dr. Malek are insufficient to meet Petitioner's burden of establishing entitlement to PTD benefits.

A claimant may also prove permanent and total disablement is by showing, by preponderance of the evidence, that she is so handicapped that she cannot be employed regularly in any well-known branch of the labor market. *Valley Mould & Iron Co. v. Industrial Comm'n*, 84 Ill.2d 538, 546–47, 50 Ill.Dec. 710, 419 N.E.2d 1159 (1981).

Ms. Weber, Respondent's vocational rehabilitation expert, at least implies in her report that Petitioner is capable of performing the duties of several jobs within Petitioner's geographic area. Petitioner offered no expert opinion to the contrary. There are recent cases in which odd lot determinations based upon the fact that there is no stable job market for a person of the claimant's age, skills, training, and work history have required

evidence from a rehabilitation services provider or a vocational counselor. *Westin Hotel v. Indus. Comm'n of Illinois*, 372 Ill. App. 3d 527, 545, 865 N.E.2d 342, 358 (2007). Here, there is no such evidence. The Arbitrator finds the evidence insufficient to establish Petitioner's entitlement PTD benefits due to the absence of a stable job market for a person of the claimant's age, skills, training, and work history.

Finally, Petitioner may prove permanent and total disablement is by showing a diligent but unsuccessful job search. *ABB* at 750. Although the Arbitrator has found Petitioner acted reasonably in her job search under the circumstances, i.e. with no professional assistance, for purposes of her entitlement to maintenance benefits, I am not convinced that the job search has been thorough enough to rule out the possibility of finding employment. Accordingly, therefore the Arbitrator finds that Petitioner has not met her burden of proving permanent and total disability using this method.

Although consideration has been given to section 8(d)1 of the Act, there is insufficient evidence in the record upon which to base an award of wage differential benefits.

The Arbitrator therefore finds that an award of permanent partial disability is appropriate in this case. The Arbitrator has looked to the case of *Ballinger, v. Montgomery Wards* 98 IL. W.C. 64402 for guidance. In that case the claimant sustained injuries and underwent a 1-level cervical fusion, attended physical therapy, treated at pain clinics for several years, and was ultimately diagnosed with failed back syndrome and chronic pain. The claimant did not return to work. The treating physician declared that petitioner "is permanently disabled from any gainful employment," but the Commission found that the claimant was capable of sedentary work with being given the ability to change positions and limit lifting. The Commission awarded 50% man-as-a-whole.

The facts are similar to the case at bar, except this case involves a lumbar fusion and not a cervical fusion. Based upon the foregoing and the record taken as a whole, the Arbitrator finds the injuries sustained by Petitioner caused the 60% loss of the person as a whole.

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

DANIEL ROBERTS,

18IWCC0429

Petitioner,

vs.

13 WC 26975

WILDFIRE RESTAURANT,

Respondent.

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

This matter comes before the Commission on Petitioner's Petition for Review Pursuant to §§19(h)/8(a). A Hearing was held in Chicago on December 19, 2017 before Commissioner Simpson. The parties were represented by counsel and a record was taken. Prior to the hearing, Petitioner acknowledged that Respondent had paid for the majority of current medical expenses and was entitled to credit therefor.

Findings of Facts & Conclusions of Law

1. Petitioner testified that his claim was adjudicated before Arbitrator Bocanegra on October 6, 2015. Since that hearing, he returned to work for Respondent. However, he "was never really completely 100%" in his abilities and "still felt strain and tightness" in his groin and right hip, as well as fatigue, pain, and discomfort in his right hip. He "never managed to get back to a full schedule at work" and was basically "giving up shifts."

2. He was getting progressively worse and returned to Dr. Dunlop on February 9, 2017. He reported that he had "difficulty getting through the shift and the pain after work was overwhelming." Dr. Dunlop referred Petitioner to Dr. Bashyal. He recommended a total hip replacement, which was performed on March 10, 2017.

3. He had postop physical therapy and work conditioning. He had a Functional Capacity Evaluation ("FCE") on August 7, 2017.

4. On October 9, 2017, Petitioner was sent to Dr. Weber for a Section 12 examination. About a week and a half after that examination, he returned to work for Respondent as a waiter. He was currently employed by Respondent in that capacity. Petitioner testified that currently he has tightness in his groin and the inside buttocks while getting out of bed in the morning and getting up after prolonged sitting or standing. "Getting in and out of the car with bending to sit down at the angle takes caution" and he notices "tightness and strain getting out and starting to walk." At work, he walks short distances and then stops and notices "strain and fatigue after the end of" a shift. Petitioner identified some medical bills that remained outstanding.

5. On cross examination, Petitioner testified he was not taking any prescription medication at the time; only "Tylenol, Advil on occasion after work." He was trying to get back to a full schedule.

6. While neither party submitted the arbitration decision, the Commission takes judicial notice of it. The decision indicates that on July 27, 2013 Petitioner sustained a fall on a wet floor in the bathroom and landed on his right hip. He sustained a "peritrochanteric hip fracture, extrascapular." He underwent internal fixation surgery ("ORIF") on July 29, 2013. Thereafter, he was an inpatient at a rehabilitation facility from August 1, 2013 to September 14, 2013. He returned to work for Respondent on November 10, 2013, in a sedentary position and on a part-time basis.

7. Petitioner consulted with Dr. Bashyal about possible hip replacement. Dr. Bashyal opined that hip replacement was not indicated at that time. After an FCE, Petitioner returned to work full time as a waiter on November 27, 2014. An AMA impairment rating indicated that Petitioner sustained 6% impairment of the right leg, or 2% of the whole person. The Arbitrator awarded Petitioner 96.75 weeks of permanent partial disability benefits, representing loss of the use of 45% of the right leg. Neither party sought review of the Arbitrator's decision.

8. The medical record shows that x-rays of the right hip taken on February 9, 2017, were compared to those taken on July 8, 2014. It was interpreted as showing "chronic findings" "similar in appearance to the prior study" with no fractures or subluxation.

9. After the x-rays, Petitioner saw Dr. Dunlap. Dr. Dunlap noted that he was 3&½ years post ORIF, "with avascular necrosis and end-stage arthritis" surgery on the right hip. He had gotten a little worse, with more pain, since he last saw Petitioner in December of 2014. Dr. Dunlap noted that the x-rays showed "advanced collapse of the femoral head." Dr. Dunlap concluded that Petitioner needed total hip replacement, and recommended Petitioner return to Dr. Bashyal.

10. On February 2, 2017, Petitioner presented to Dr. Bashyal for a new problem, which was described as worsening pain and collapse of his right hip. Dr. Dunlap informed Petitioner he had avascular necrosis. Petitioner reported that his pain had been increasing over the past several months. Dr. Bashyal noted that several previous x-rays showed that things were fine, "but now he has gone into AVN collapse." He recommended removal of hardware and complex hip arthroplasty. Petitioner agreed.

11. On March 10, 2017, Dr. Bashyal performed complex right total hip arthroplasty with conversion of prior hip surgery to total hip arthroplasty with removal of hardware, for right hip avascular necrosis subsequent collapse after hip fracture ORIF.

12. By June 29, 2017, Petitioner was doing well 15 weeks post arthroplasty. X-rays showed the arthroplasty was in appropriate position with no signs of loosening or failure. Petitioner would continue to work with physical therapy. Dr. Bashyal would follow up with Petitioner in one to two years.

13. Petitioner had an FCE on August 7, 2017, which was considered valid. He functioned at the medium physical demand level, which was the physical demand level of his job as waiter. He could lift 52.8 lbs above shoulder, 67.8 lbs desk to floor, 57.8 lbs chair to floor, and carry 47 lbs with both arms. He had physical therapy for six weeks and work hardening for another five weeks.

14. Respondent submitted a report dated October 9, 2017, authored by Dr. Weber pursuant to Section 12 of the Act. Dr. Weber noted Petitioner's accident. Alternatives for treatment for his hip fracture was ORIF or hip replacement, ORIF was chosen because of Petitioner's age. He never got back to 100% after the surgery and always had some tightness in his groin. His hip pain progressed eventually resulting in antalgic gait. He never got back to full duty or more than four shifts a week.

15. Dr. Weber noted that Petitioner's pain progressed, and he was told he had avascular necrosis and collapse of the femoral head. He had right hip arthroplasty followed by physical therapy and work hardening. He had an FCE. His doctor deferred about his return to work even though the FCE indicated that he had the physical capabilities to perform his job, and suggested he see an occupational doctor.

16. Currently, Petitioner reported some discomfort in the groin area with prolonged sitting, sleeping, or driving. Dr. Weber's examination was within normal limits for a patient who had hip arthroplasty. The objective findings of her examination were normal and did not correlate to his complaints. Petitioner was at maximum medical improvement and no additional treatment was necessary, though she recommended a home exercise program for strengthening. Based on the FCE results and the job description, Petitioner could return to work at his prior job without restrictions.

18IWCC0429

Petitioner seeks an additional award of loss of 20% of the use of his right leg, as well as payment of all outstanding medical expenses. Respondent concedes that it is responsible for the outstanding bills but argues an increase in permanent partial disability benefits is not warranted because he had no ongoing treatment and was able to perform his prior job without restrictions. The Commission finds that the treatment Petitioner received since his arbitration hearing was necessary and reasonable and causally related to his initial work-related accident on July 27, 2013. Therefore, the Commission awards all medical expenses submitted by Petitioner incurred since the hearing.

On the issue of permanent partial disability, the Commission reviewed prior Commission awards for hip arthroplasty. The range of permanent partial disability awards generally ranged between loss of 45% of the leg to loss of 60% of the leg. The lower end of the awards tended to involve accidents that aggravated existing osteoarthritis. The higher end of the awards tended to involve some permanent restrictions, limitations, and/or change of occupations. In the instant claim, there is no evidence that Petitioner had pre-existing osteoarthritis and it appears that the acute accident was the direct cause of the initial ORIF surgery and later arthroplasty. On the other hand, Petitioner was able to return to his prior job with no restrictions. In the original arbitration, Petitioner was awarded 96.75 weeks of permanent partial disability benefits, representing loss of use of 45% of the right leg. In looking at the entire record before us, the Commission finds that an additional award of 16.125 weeks of permanent partial disability benefits, representing an additional loss of 7.5% of the use of the right leg, for a total loss of 52.5% of the right leg is appropriate in this matter.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review Pursuant to §§19(h)/8(a) is hereby granted.

BE IT FURTHER ORDERED BY THE COMMISSION that Respondent pay all outstanding medical expenses incurred for the treatment of Petitioner's right hip since the arbitration hearing submitted into evidence by Petitioner, subject to the applicable fee schedule.

BE IT FURTHER ORDERED BY THE COMMISSION, that Respondent pay Petitioner the sum of $258.18 a week for an additional 16.125 weeks because Petitioner has sustained the loss of the use of an additional 7.5% of his right leg.

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: JUL 12 2018

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

DLS/dw
O-6/28/18
46

Stephen J. Mathis

Stephen J. 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

Scott Cook,

Petitioner,

vs. NO: 12WC 29305

18IWCC0430

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, temporary total disability, 8(d)1 wage differential benefits 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 25, 2017, is hereby affirmed and adopted.

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

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

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

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

DATED: JUL 12 2018

Michael J. Brennan

David L. Gore

Kevin W. Lamborn

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MJB/jrc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COOK, SCOTT
Employee/Petitioner

Case# **12WC029305**

CITY OF CHICAGO
Employer/Respondent

18IWCC0430

On 9/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON
MATTHEW M GANNON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

1401 SCOPELITIS GARVIN LIGHT ET AL
GERALD F COOPER
30 W MONROE ST SUITE 600
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

SCOTT COOK
Employee/Petitioner

v.

CITY OF CHICAGO
Employer/Respondent

Case # **12** WC **29305**

Consolidated cases:

18IWCC0430

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros,** Arbitrator of the Commission, in the city of **Chicago**, on **7/24/2017.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 **8(d)1 wage differential benefits**

FINDINGS

On the date of accident, 5/21/2011, 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 **$93,808.00** the average weekly wage was **$1,804.00.**

On the date of accident, Petitioner was **40** years of age, ***single*** with **0** dependent children.

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

ORDER

Respondent to pay Petitioner permanent partial disability benefits commencing on July 24, 2017, of $930.39 per week until the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)(1) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical free schedule of $7,874.55 to Bone & Joints Physicians/Dr. Joseph Thometz and Ridge Orthopedic & Rehab as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner Maintenance Benefits of $1,202.73/ week for 98 weeks, representing the periods of April 4, 2015 through October 15, 2015 and May 28, 2016 through July 24, 2017, 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.

#001 Arb. George J. Andros

Signature of Arbitrator

9/22/17

Date

ICArbDec19(B)

SEP 25 2017

STATEMENT OF FACTS 12 WC 29305

The parties stipulate Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on May 23, 2011. His permanent restrictions prevent him from performing all of the normal work duties of a Local 150 Operating Engineer. Respondent has provided vocational rehabilitation services to Petitioner intermittently from December 20, 2012 to May 10, 2016. The issues in this matter are what is the appropriate award under 8(d)(1) of the Act, whether Respondent is liable for unpaid medical bills, and whether Respondent is liable for any unpaid maintenance benefits.

Additionally, the parties have stipulated that Petitioner's earnings during the year preceding the injury were $93,808.00, and the average weekly wage was $1,804.00. The parties have also stipulated that petitioner would currently earn in the full performance of his duties as a a Local 150 Operating Engineer with the City of Chicago is $95,888.00. The average weekly wage he would be earning in the full performance of his duties is $1,844.00 by agreement of the parties. .

Petitioner's medical treatment

On the date of the accident, Petitioner reported to Dr. Homer Diadula at Mercy Works with complaints of pain in the right shoulder, neck and upper back. Dr. Diadula diagnosed Petitioner with a neck strain, shoulder strain and mid-back strain and instructed Petitioner to remain off work. Petitioner returned to Dr. Diadula on June 2, 2011 with limited range of motion in the cervical spine and pain in the right shoulder. Dr. Diadula recommended an MRI of the right shoulder to rule out a tear. Petitioner underwent an MRI of the right shoulder on June 27, 2011, which showed an extensive partial thickness tear of muscles within his rotator cuff.

On July 6, 2011, Petitioner came under the care of orthopedic specialist, Dr. Joseph Thometz at Bone and Joint Physicians. Upon review of the June 27, 2011 MRI, Dr. Thometz recommended surgical intervention consisting of a right shoulder rotator cuff repair. Petitioner continued to follow up with Dr. Diadula who confirmed Dr. Thometz's diagnosis of a rotator cuff tear and recommendation that Petitioner remain off work. Petitioner returned to Dr. Thometz on September 28, 2011 with continued complaints of pain and discomfort in the right shoulder, neck pain and discomfort through the mid to lower cervical spine with some pain radiating into his hand. Dr. Thometz provided Petitioner with pain medication until approval of the recommended surgery.

On January 19, 2012, Dr. Thometz performed surgical intervention consisting of a right shoulder arthroscopy, debridement of the labrum, subacromial decompression and repair of the rotator cuff. On January 30, 2012, Dr. Thometz recommended Petitioner begin physical therapy. He instructed Petitioner to remain off work. Petitioner underwent 58 sessions of physical therapy from February 7, 2012 through August 10, 2012. Petitioner continued to follow up with Dr. Thometz who instructed him to remain off work while progressing through physical therapy.

On May 14, 2012, Petitioner returned to Dr. Thometz with tightness and decreased mobility. Petitioner reported that there was a lapse in his therapy due to non-approval and he was forced to attempt home exercises on his own.

On June 11, 2012 Petitioner returned to Dr. Thometz five months post-surgery. Dr. Thometz noted Petitioner had the ability to lift 4 pounds overhead, had soreness anteriorly and limited strength. He ordered restrictions of no use of the right arm and recommended another month of physical therapy. On July 16, 2012, Dr. Thometz recommended Petitioner undergo 3 additional weeks of physical therapy and a functional capacity examination to determine his work status.

Section 12 exam for Respondent by Dr. Greg Westin

On November 7, 2011 Petitioner presented to Dr. Westin for a medical examination pursuant to Section 12 of the Act regarding his right shoulder. (PX#8). During his examination, Petitioner stated that he underwent a prior surgery on his right shoulder approximately 15 years earlier. (PX#8). This previous surgery was a labral repair, which included an arthroscopy and subsequent open repair. Petitioner reported that his right shoulder functioned well after that surgery.

Dr. Westin noted that Petitioner's job description requires climbing into cabs of heavy equipment, frequent lifting of 35 pounds, and occasional lifting of up to 100 pounds. Dr. Westin opined that the lifting goal of 100 pounds was "risky." (PX#8). At that time, Dr. Westin anticipated that Petitioner's future lifting capacity would be a maximum of 50 pounds in order to prevent a re-tear of the shoulder. (PX#8). Dr. Westin opined that Petitioner would require assistance with trailer ramps or similar occasional heavy lifting and that he would be limited to clerical work initially because he is right handed. (PX#8).

Dr. Westin's review of Petitioner's MRI showed a nearly full-thickness tear of the distal supraspinatus tendon. (PX#8). Dr. Westin also observed evidence of metallic artifact on the glenoid from prior surgery. He diagnosed Mr. Cook with persistent pain from a right rotator cuff tear. (PX#8). Dr. Westin opined that the history of injury provided by Petitioner was consistent with his diagnosis. (PX#8). Dr. Westin noted that although Petitioner's shoulder had pre-existing conditions, the prior issues were related to the labrum not to the rotator cuff. (PX#8).
Dr. Westin opined that Petitioner's diagnosis was supported by the medical records and objective findings and recommended a surgery consisting of a right shoulder arthroscopy, acromioplasty and possible rotator cuff repair. (PX#8).

Dr. Westin opined that Mr. Cook was not at maximum medical improvement for the injury of May 23, 2011. (PX#8). He anticipated that Mr. Cook would be at maximum medical improvement one year following his surgical date and that he would have permanent restrictions. (PX#8).

Section 12 exam with Dr. Andrew Zelby on August 22th , 2016

Dr. Zelby reviewed Petitioner's work capacity evaluation dated August 13, 2012 and determined it to be valid. Dr. Zelby opined that Mr. Cook demonstrated the ability to work in a medium physical demand level. (PX#9).

In addition to the work capacity evaluation, Dr. Zelby reviewed extensive vocational rehabilitation notes. Dr. Zelby also reviewed Petitioners medical records and job description, which indicated Mr. Cook would be required to frequently lift and carry materials up to 35 pounds and occasionally lift and carry up to 100 pounds. Dr. Zelby opined that Petitioner sustained an injury to his shoulder, but did not believe that Petitioner sustained an injury to his cervical spine or nervous system as a result of his May 23, 2011 work accident. (PX#9).

Work Capacity Evaluation

On August 13, 2012, Petitioner reported to Mary Lee, OTR, NovaCare Rehabilitation for a work capacity evaluation. (PEX#7). Ms. Lee opined that the results of Petitioner's evaluation can be considered an accurate representation of his true tolerance to work demands. (PEX#7).

Upon her evaluation of Mr. Cook, Ms. Lee opined that he demonstrated an ability to function in the Medium Physical Demand Level according to the US Department of Labor Standards. (PEX#7). These results indicated that Mr. Cook did not demonstrate the ability to work at a Heavy Physical Demand Level, which was required for his position as a Hoisting Engineer for the City of Chicago. (PEX#7). Ms. Lee made this determination based on the job requirements provided by the employer with clarification for ranges for lifting and positional tolerances provided by the client and the US Department of Labor Standards. (PX#7).

During her evaluation, Ms. Lee noted that Mr. Cook's deficiencies included: two handed lifting and carrying, two handed pushing and pulling, climbing in and out of vehicles, and reaching overhead. (PEX#7). She opined that Mr. Cook would not be able to progress to meet the demand levels of his job, including lifting and carrying 100 pounds. Ms. Lee's findings are included below:

Material Handling:	**Frequent (33%-66%)**	**Constant (66%-100%)**	**Job Position (Per employer/client)**	**Comments**
Lift – floor to waist	15 lbs	N/A lbs	100# Occ/35# Freq	Not Met
Lift – waist to shoulder	15 lbs	N/A lbs	100# Occ/35# Freq	Not Met
Lift – Shoulder to overhead	10 lbs	N/A lbs	100# Occ/35# Freq	Not Met
Carry – Bimanual	15 lbs	N/A lbs	100# Occ/35# Freq	Not Met
Push	35 lbs	N/A lbs	Ratchet/Levers/chains	Not Met
Pull	35 lbs	N/A lbs	Ratchet/Hose/chains	Not met

Positional Tolerance:	**Frequency**	**Job Position**	**Comments**
Climb in/out of truck	Occasional	Occasional	Job function not met
Reach Overhead	Occasional	Occasional	Job Function Not Met

(PEX#7).

MedVoc Rehabilitation

On November 20, 2012, Respondent initiated a course of vocational rehabilitation services for Petitioner through MedVoc Rehabilitation, Ltd. (PX#12). Petitioner remained in vocational rehabilitation intermittently from November 20, 2012 through May 10, 2016. (PX#12). Neither Respondent nor MedVoc offered any additional training to Petitioner in order to better meet the skill requirements to obtain gainful employment. (PX #10). MedVoc Rehabilitation's job goals for Petitioner were focused on dispatching and managerial positions for which both vocational rehabilitation experts determined that he was not qualified for by education and/or experience. (PX #10). The evidence is devoid of any approved rehabilitation plan per Rule 7110. of the Workers Compensation Commission.

Paystubs from Security Intelligence Group

After unsuccessful attempts of securing a job through MedVoc Rehabilitation, Petitioner secured a position for himself in the photocopy room of Security Intelligence Group, Inc. in March 2016. Petitioner worked for Security Intelligence for approximately one month. During that time he earned $8.75 per hour. He received two paychecks totaling $1,293.19, one on April 2, 2016 in the amount of $618.75 and another on April 16, 2016 in the amount of $674.44. (PX#15).

Vocational Expert James Boyd

On May 31, 2016, Petitioner was evaluated by vocational rehabilitation expert James F. Boyd, M.S., CRC, LCPC, PVE. Mr. Boyd conducted an interview and administered a battery of vocational testing. (Px. 10)

Mr. Boyd's impression indicates that the medical release and restrictions from Dr. Thometz are clear regarding Mr. Cook's inability to return to work as a hoisting engineer. Mr. Boyd noted that Petitioner was a member of Local 150 Operating Engineers Union and worked as an independent heavy equipment operator for eight years prior to beginning his employment with the City of Chicago's Department of Transportation in 2008. Mr. Boyd notes that Petitioner earned an hourly wage of $45.10 per hour at the time of the injury in 2011. (PX #10).

Mr. Boyd noted that Petitioner was released from medical care with a 20-pound maximum lifting limit and no overhead activity with the right upper extremity. Mr. Boyd reported that vocational rehabilitation services were provided by the Respondent though MedVoc Rehabilitation, Ltd. but were discontinued as of May 10, 2016. Mr. Boyd reported that MedVoc Rehabilitation's job goals for Petitioner were focused on dispatching and managerial positions for which he was not qualified by education and/or experience.). He was of the opinion that Petitioner has no keyboarding skills or knowledge of Microsoft Office and Excel programs. .

The Arbitrator under scored and finds very probative that Mr. Boyd noted that Petitioner was never offered any additional training by the Respondent or MedVoc Rehabilitation to better meet

the skill requirements for these jobs. At the time of Mr. Boyd's assessment, Petitioner found full-time employment on his own in a photocopy room of Security International Group earning an hourly wage of $8.75 per hour. (PX #10). (emphasis added)

Mr. Boyd opines that Petitioner presents few skills from his employment history that are transferable to alternate jobs within his current physical abilities. (PX #10). Mr. Boyd believes that at minimum, Petitioner would require some prerequisite training (emphasis added) to acquire keyboarding skills and a basic utilization of Microsoft Office and Excel software, since computer access would be required for most any job within his functional capacity. (PX #10). (Emphasis added)

Mr. Boyd used the Illinois Department of Employment-Security Wage Data (2015) for the Chicago metropolitan statistical area to determine Petitioner's "possible" earning capacity. (PX #10). Mr. Boyd concluded that the entry hourly wages for jobs that Mr. Cook could consider with appropriate training (emphasis added) are as follows:

	Entry
Customer Service Representative	$11.60
Order Clerk	$12.26
Billing Clerk	$13.70
General Office Clerk	$10.55
Information Clerk	$10.20
Shipping Clerk	$11.02
Security Guard	$10.16

(PX #10)

Vocational Expert Lisa Byrne

On June 14, 2017, Petitioner was evaluated by a second vocational rehabilitation expert Lisa Byrne, M.A., CRC, LCPC, PVE. (PX #11). Ms. Byrne noted that since meeting with Mr. Boyd, Petitioner reported that he could no longer afford his home in Chicago and moved to Arkansas. (PX #11).

Ms. Byrne reported that Petitioner still experiences daily pain in his right shoulder, has lost strength in his arm, it is currently frozen again, and he doesn't have any external rotation, but is in need of an MRI before any treatment options can be considered. (PX #11). Ms. Byrne noted that Petitioner uses his tens unit a few times a week to help with his pain. (PX #11).

Ms. Byrne noted that Petitioner had been working for Security International Group in October 2016 earning $8.75 per hour. (PX #11). His duties included making photocopies and running errands, but said this job only lasted a few weeks and he was let go because there wasn't any more work. (PX #11). Petitioner still has a LinkedIn profile that he checks and has continued to apply for jobs that he is qualified, but this hasn't resulted in any employment offers or interviews. (PX #11). Ms. Byrne reported that Petitioner recently applied for a Port Director's

position and an Operations Manager's position, but hasn't received any responses from his applications. (PX #11).

Ms. Byrne noted that Petitioner had completed several certifications through the National Rifle Association (NRA) to work as a firearms instructor in Arkansas but experiences pain when shooting, and found there isn't much work for him there. (PX #11).

Ms. Byrne reported that Petitioner has limited computer skills. Ms. Byrne noted that Petitioner has very limited and slow hunt-and-peck typing abilities, and is not familiar with any common programs such as MS Word, Excel, or PowerPoint. (PX #11).

Ms. Byrne opined that she is in agreement with the potential occupations and wage data information for Petitioner listed in Mr. Boyd's report, which remain current and accurate wages as of June 14, 2017. (PX #11).

Ms. Byrne is also of the opinion that these occupations would require some type of training before Petitioner could access them, such as security training, keyboarding, and computer software program knowledge, which would be required of most jobs within his functional capacity. (PX #11). Additionally, Ms. Byrne was of the opinion that these jobs should be viewed selectively depending on the specific skill requirements and production expectations as Petitioner did demonstrate slow and inaccurate performance with clerical perception. (PX #11). Ms. Byrne opined that Petitioner's slow and inaccurate performance with clerical perception indicated that even with training he may likely require additional time and/or accommodations. (PX #11). (emphasis added)

CONCLUSIONS OF LAW

ISSUE (O) 8(d)(1) wage differential benefits

The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he is entitled to a wage differential award under Section 8(d)(1) because he has suffered an impairment of his earning capacity that prevents him from fully returning to his usual and customary work as a Local 150 Operating Engineer. Under Section 8(d)(1), an impaired worker is entitled to a wage differential award when (1) he is partially incapacitated from pursuing his usual and customary line of employment and (2) there is a difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he is earning or is able to earn in some suitable employment or business after the accident. 820 ILCS 305/8(d)(l) (West 2012), *Id.* at 40. Here, Petitioner has met both prongs of this test.

The Arbitrator relies on the reports of both vocational rehabilitation experts in this matter. Importantly, both vocational rehabilitation experts are of the opinion that Petitioner is in need of training in order to obtain employment.

Despite providing vocational rehabilitation services to the Petitioner intermittently from December 20, 2012 through May 10, 2016, the Arbitrator does not have a rehabilitation plan pursuant to Section 7110.10 to rely upon.

Based upon a detailed study of all the reports the Arbitrator finds that all the projections of what he " earns or is able to earn " is totally speculative under Deichmueller case and the very latest case of Carl *Crittendon v. City of Chicago* –except for the actual job he did obtain for the security company at $ 8.75 per hour. The Arbitrator can not under the latest law pick a job , so to speak unless it's a real job with specific wage information that from the record, the worker is able and qualified to perform. (emphasis added) The Arbitrator can not put conditions either precedent or subsequent on any attempt at projections of what he is "capable of earning " at present unless the basis for determination is in the record as to what is now able and qualified to perform.
See *Critenden* 2017 IL App (1st) 160002 WC.

Therefore, in awarding 8(d)(1) benefits, the Arbitrator must elect to adopt the analysis in *Critenden* given the Arbitrator has no option but to follow the precedent of the Appellate Court of Illinois. The evidence in the four corners of the record is that Petitioner is able and qualified of earning $8.75 an hour or $350 per week assuming a 40 hour work week. . Remember, that no true training or rehabilitation was ever offered nor performed by Med Voc, chosen by the Employer, City of Chicago.

The Arbitrator can not then simply rely upon some potential, compromise wage number essentially established by a labor market survey. MedVoc under the Rules of Practice and the gold standard of the *National Tea* case , has not provided the appropriate training to direct some higher outcome for his own wage.

The Arbitrator finds the Petitioner is able to earn an average of $350 per week post injury under Section 8(d)(1) of the Act. The petitioner would earn in the full performance of his duties as of the date of arbitration $1,844 per week. The petitioner's weekly wage loss is therefore $1,494. Two thirds of $1,494 is $996 per week. The statutory maximum PPD weekly rate in effect for wage loss for the date of injury is $930.39. The Petitioner is therefore entitled to $930.39 per week commencing on July 24, 2017 and continuing for the duration of his disability pursuant to Section 8(d)(1) of the Act.

ISSUE (J) Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The parties have stipulated that Petitioner sustained accidental injuries that arose out of and in the course of his employment to Petitioner's right shoulder. Additionally, there has been no evidence presented and no objection concerning reasonableness and necessity of Petitioner's medical treatment. Petitioner offered into evidence Petitioner's Exhibit #16, line #1, a medical bill itemization from Bone & Joint Physicians/Dr. Joseph Thometz and Ridge Orthopedic & Rehab. (PX #16). Petitioner claims a total of $7,874.55 remains unpaid. (PX #16).

The Arbitrator finds Respondent is ordered to pay the Petitioner and his attorney the above sum for medical expenses found in Petitioner's Exhibit #16, line #1, pursuant to the fee schedule.

ISSUE (O) Unpaid Maintenance benefits

Respondent refused to pay Petitioner maintenance benefits for the time periods of April 4, 2015 to October 16, 2015 and again from May 28, 2016 up to the date of the hearing, July 24, 2017. Petitioner underwent an emergency gallbladder surgery on April 15, 2015 with Dr. Peter Neale. Dr. Neale prohibited Petitioner from engaging in vocational rehabilitation following this surgery. Petitioner suffered a pulmonary embolism immediately following this surgery and required additional time to recover from his illness. Respondent's vocational company, MedVoc, was informed of Petitioner's condition, and noted in their May 17, 2015 vocational report to Respondent that vocational rehabilitation would resume 8 weeks later as indicated by Petitioner's doctors. Mr. Cook was cleared to return to vocational rehabilitation on July 27, 2015 by Dr. Kumaraiah. Respondent failed to initiate maintenance benefits at that time, including both vocational counseling and payment to Petitioner in violation of Section 8(a) of the Act.

On October 17, 2015, after 33 weeks of failing to make payments, Respondent again began issuing maintenance payments to Petitioner. Respondent's vocational counselor was unsuccessful in finding Petitioner gainful employment and Respondent did not elect to authorize retraining or education to help Petitioner find new employment. Respondent ultimately stopped all maintenance benefit payments on May 27, 2016. Petitioner has not received any maintenance benefits from May 28, 2016 through the time of trial on July 24, 2017 (60 weeks).

The Act states an employer shall pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto. 820 ILCS 305/8(a).

Vocational rehabilitation may include, but is not limited to, counseling for job searches, supervising a job search program, and vocational retraining including education at an accredited learning institution. 820 ILCS 305/8(a). The maintenance benefit shall not be less than the temporary total disability rate determined for the employee. 820 ILCS 305/8(a).

The parties have stipulated that Petitioner's earnings during the year preceding the injury were $93,808.00, and the average weekly wage was $1,804.09. Therefore his maintenance rate is $1,202.73. The Arbitrator finds that Respondent failed to make appropriate maintenance payments to Petitioner pursuant to Section 8(a) of the Act in the amount of $33,676.44 for the period of April 4, 2015 through October 16, 2015 and $72,163.80 for the period of May 28, 2016 through Or july 24, 2017

Based upon the totality of the evidence, the Arbitrator orders Respondent to pay Petitioner and his attorney the total sum of $105,840.24 in outstanding maintenance benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Highland,

Petitioner,

vs. NO: 16WC 28640

18IWCC0431

WFF Facility Services,

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, evidentiary issues, 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 10, 2017, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,000.00. 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: JUL 12 2018

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JDL/jrc
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David E. Gore

Kevin W. Lamborn

Joshua D. Luskin

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

HIGHLAND, JOHN
Employee/Petitioner

Case# **16WC028640**

WFF FACILITY SERVICES
Employer/Respondent

18IWCC0431

On 7/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1609 BOTTO GILBERT LANCASTER PC
FRANCISCO BOTTO
970 McHENRY RD
CRYSTAL LAKE, IL 60014

0766 HENNESSY & ROACH PC
TAMMY PAQUETTE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF McHenry)

☐ 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)

John Highland
Employee/Petitioner

v.

WFF Facility Services
Employer/Respondent

Case # 16 WC 28640

Consolidated cases: N/A

18IWCC0431

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Waukegan**, on **March 29, 2017 and the** city of **Woodstock**, on **May 3, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0431

FINDINGS

On the date of accident, **August 4, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

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

On the date of accident, Petitioner was **61** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$1,500.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$1,500.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $266.67/week for 39 weeks, commencing August 5, 2016 through May 3, 2017, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$1,500.00** for TTD paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for treatment incurred for Petitioner's condition of ill being in the left hip and related complications including the post surgical infection, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical benefits that have been paid pursuant to a group medical plan under Section 8(j), and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for additional reasonable and necessary treatment to the left hip and leg or complications related thereto consistent the recommendations of Dr. Moe or Dr. Noor.

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

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

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

Signature of Arbitrator

July 5, 2017
Date

ICArbDec19(b)

JUL 10 2017

Statement of Facts

The Petitioner, John Highland, was employed by the Respondent, WFF Facility Services, as a custodian. Petitioner testified that he had been in that position for approximateiy 9 years. Petitioner testified that on August 4, 2016, he was working at Antioch High School. He was familiar with the surroundings. He was performing inventory. He was looking for a vacuum cleaner. At about 3:20 PM, he entered the kitchen and then the dry food storage room. He testified that the vacuum would not normally be in the kitchen but during the summer, things are put all over. Petitioner prepared a diagram of the layout of this area as PX 4. The lights were out in the kitchen but there was light entering through the windows in the double doors from the hallway. Upon entering the kitchen, the ice machine is to the right and the storage room is to the left.

Petitioner testified he checked the ice machine. He testified that there is water on the floor from condensation. He could see water on the floor. During the school year, there is a rubber mat, but it was not there on August 4, 2016. He testified that he then headed to the dry food storage room. He described the dry food storage room. It is L shaped. You need to push the door open. The light switch is 6-7 feet into the room on the north wall. There is a desk on the left side of the room. He testified that he entered the room and headed to the switch. He could not see it, but he knew where it was. He testified that his feet went out from under him. He went to grab the desk and landed on his left side. He testified that he slipped because he had water on his tennis shoes from the ice machine.

Petitioner testified that he felt pain in his left hip and leg. Petitioner remained on the ground and yelled for help. About 2 minutes later, John, a coworker, came to help. John got a wheelchair moved him to the main shop. Petitioner called his boss George Villagomez and informed him of the accident. Petitioner testified that he spoke with Mr. Villagomez who travelled to the scene from another location in order to investigate the matter before being transported by ambulance to the hospital.

George Villagomez testified that he is the manager for Respondent. On August 4, 2016, he was working at a different location when he got a telephone call from Petitioner. He arrived about 10 minutes later. He had a conversation with Petitioner at that time. Petitioner was sitting in the wheelchair. He was no longer at the scene of the accident. He testified Petitioner told him he was walking into the kitchen and felt that his leg gave out. He completed his report based upon what he was told. The report was admitted as RX 3. He testified that the Employee Injury Report (PX 5) was also prepared at that time and was a part of the submission. Mr. Villagomez testified that he completed his investigation. He went to the site of the accident and took pictures admitted as RX 2A-D. The floor is concrete. It is rough, not slippery. He testified that the ice machine is 12-16 feet from the storage room. He looked at the ice machine. There was no water on the floor. He testified that the mat is always by the ice machine. There was no reason for Petitioner to check the ice machine that day.

Petitioner had previously had surgery for a total left hip replacement on June 20, 2016. He began treatment with Dr. Antonacci on April 8, 2016 for left hip pain with no known injury. Petitioner was seen by PA-C Kaitlin Georgiafandis on July 5, 2016 and advised he felt ready to return to work without restrictions. Petitioner was advised to continue medication and was to begin out patient physical therapy. He was allowed to drive as long as he felt he could slam on the brakes. Petitioner was scheduled for follow up on August 5, 2016. This visit was cancelled due to his August 4, 2016 fall (RX 1). Petitioner testified that he did not begin therapy before August 4, 2016. Petitioner testified that he had been released and was working full duty without complaints for approximately one month. Mr. Villagomez testified that Petitioner had returned to work without restrictions on July 6, 2016.

After the injury, Petitioner went to the emergency room at United Hospital System in Kenosha Wisconsin on August 4, 2016. Petitioner provided a history to Dr. Falco that he slipped on a wet floor and landed on his left hip (PX 2, p 59). Dr. Nanul recorded a history that he slipped and fell where there was some liquid on the ground (PX 2, p 102). X-rays showed a displaced proximal left femoral shaft fracture adjacent to the left hip prosthesis (PX 2, p 104). On August 5, 2016, Petitioner had surgery by Dr. Craig Moe. He performed a total hip arthroplasty and revision of femoral stem (PX 2, p 111-13). Dr. Moe noted a history that Petitioner slipped on some water, felt a crack in his leg and fell to the ground (PX 2, p 111). Petitioner was discharged on August 9, 2016 (PX 2, p 114-115).

Petitioner followed up with Dr. Moe through September 6, 2016 and continued to show progress. On September 14, 2016, Dr. Moe noted that the wound was red and swollen and that Petitioner had fluid collecting under the surface. Dr. Moe believed there was an infection and that Petitioner was in need of a revision surgery (PX 6). On September 19, 2016, Petitioner sought treatment at the emergency room of United Hospital System for bleeding from his surgical wound (PX. 6, p 1194). He was admitted for treatment and transferred to Kenosha. Petitioner underwent a resection to left total hip arthroplasty with placement of antibiotic spacer by Dr. Moe on September 21, 2016 (PX 2, p 74-76). Petitioner continued treatment of his infection with Dr. Salman Noor. Petitioner was discharged on September 29, 2017 (PX 6).

Petitioner had further infection. On October 17, 2016, he underwent irrigation and debridement of his left hip wound with placement of a wound vacuum (PX 6, p 1360). On October 18, 2016, he was admitted for treatment of an infection through a discharge on October 19, 2016 (PX 6, p 1359). Petitioner had follow up treatment with Dr. Moe for continued infection. On January 11, 2017, Dr. Moe agreed to a further revision surgery (PX 7, p 788-802). On January 25, 2017 Petitioner underwent an additional left hip total arthroplasty resection arthroplasty incision and drainage with placement of a new antibiotic spacer (PX 7, p 585-587). He was discharged on January 30, 2017 (PX 7, p 619).

Petitioner continued follow up with Dr. Moe. In February, 2017, the hip arthroplasty and femur fracture had healed in good anatomic alignment. On March 9, 2017, Dr. Moe noted that the wound is finally healed. Petitioner was to stay on antibiotics per Dr. Noor. Petitioner was progressed to full weight bearing and to increase walking in physical therapy. Petitioner was scheduled for follow up in 4 weeks (PX 7, p 841-843).

On March 29, 2017, Petitioner testified that he was ordered off work from the date of the injury to the date of trial. Off work slips from the date of accident through March 8, 2017 were admitted as PX 1. Petitioner testified that he was still under active treatment and had additional appointments scheduled with Dr. Moe in April, 2017. Petitioner admitted an updated work status note taking Petitioner off work beginning April 7, 2017 for the next two months (PX 8).

Petitioner admitted PX 3 and PX 9 with respect to the medical bills incurred. Petitioner testified that his bills are being paid through Blue Cross/Blue Shield. He has not paid any bills himself.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury occurs "in the course of" employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. The undisputed facts confirm that Petitioner's injury occurred while he was performing the inventory at his assigned job location. These undisputed facts confirm that the injury occurred in the course of his employment. The dispute is whether the injury "arose out of" the employment.

An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. At the time of his fall, Petitioner was performing a search to fulfill his job duties. The question is whether the fall was caused by a risk of the employment.

There are three categories of risks an employee may be exposed to: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics." *Illinois Institute of Technology v. Industrial Comm'n*, 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 247 Ill. Dec. 22 (2000). The mere fact that the claimant's duties took him to the place of injury and that, but for her employment, he would not have been there, is not sufficient, of itself, to support a finding that her injuries arose out of her employment. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 485-86, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989); *Caterpillar Tractor Co.*, 129 Ill. 2d at 63. A pure unexplained fall is not compensable in Illinois, as it does not satisfy the "arising out of" requirement. By itself, the act of walking across a floor at the employer's place of business does not establish a risk greater than that faced by the general public. Employment related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work related task which contributes to the risk of falling.

Petitioner is alleging a work related risk based upon three elements: the lack of light at the scene of the fall, a desk in the storage room creating a hazard, and a slip on water tracked by Petitioner from the ice machine. Respondent is alleging that Petitioner suffered a personal risk based upon an idiopathic fall when his leg gave out as a result of his recent hip replacement surgery. Despite evidence that the area may have been dark, and that there was a desk in the room, Petitioner did not attribute his fall to any condition other than slipping on the wet floor either in his testimony or any of the medical histories. His testimony provided no evidence that either the darkness or the desk contributed to the fall. The claimant must show more than a mere possibility of an increased risk of injury from his employment. It is not the employer's burden of proof to disprove the existence of an increased risk of injury. *Ghere v. Industrial Comm'n*, 278 Ill.App.3d 840, 215 Ill.Dec. 532, 663 N.E.2d

1046 (1996). Therefore, the only employment risk to be considered that may have been a cause of the accident is Petitioner slipping on a wet floor.

Petitioner credibly testified to water on the floor near the ice machine and that his shoes got wet. He then testified that he slipped on the floor in the storage room because of the water he tracked in. Petitioner gave a consistent history of slipping on the wet floor to the emergency room physicians and surgeon. The Arbitrator finds Petitioner's version of the accident persuasive. While there are minor variations in the history, and the distance from the ice machine to the location of Petitioner's fall was 16 feet so that he would have taken several steps before falling, the consistent reporting of slipping on water in the emergency room is compelling to the Arbitrator and credible.

Mr. Villagomez testimony is less persuasive. He did not arrive at the site until at least 10 minutes later. Petitioner had already been moved to the main shop and was awaiting the ambulance. Petitioner would have been in distress from his injury. The report was prepared from what must have been a brief conversation. Petitioner did not prepare or sign any of the accident reports. Petitioner denied giving the version of the accident in the reports. The Arbitrator attributes no insidious intent to Mr. Villagomez, but believes that there was simply a miscommunication or misinterpretation of the event coupled with his understanding of Petitioner's prior hip surgery. Mr. Villagomez further investigation, including the photographs taken, was based upon his understanding of the incident as noted in the report that Petitioner simply fell at the location inside the storage room. While the photographs accurately depict the floor and the lack of any defect, they were taken at least 15 minutes after the injury and any wetness from Petitioner's shoes would not have been still there. Mr. Villagomez testimony about the ice machine is unpersuasive since based upon his understanding of the incident, there was no reason for him to observe, inspect or document the condition of the floor by the ice machine. The Arbitrator notes that Respondent did not introduce any expert opinions to support their theory that the fall was caused by the pre-existing hip condition alone.

Petitioner slipping on water tracked on his shoes from the ice machine is not a risk to which the general public is exposed and is an increased risk of the employment.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on August 4, 2016.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being.

In *Nanette Schroeder v. Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC, No. 4-16-0192WC (May 31, 2017), the Appellate Court has recently addressed the standard of establishing causation where there is an aggravation of a pre-existing condition and whether the chain of events to establish causation is applicable. It is well-established that an accident need not be the sole or primary cause—as long

as employment is a cause—of a claimant's condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003). Furthermore, an employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36 (1982). If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been.

Petitioner had a left hip replacement on June 20, 2016. Even though this was only a few weeks earlier, he returned to full duty work on July 6, 2016 and worked unrestricted duty until the August 4, 2016 accident. Thereafter, he suffered immediate increased pain and loss of function in the left leg. He was diagnosed with a displaced proximal left femoral shaft fracture adjacent to the left hip prosthesis and underwent immediate surgery. Thereafter, he has been continuously under care for the hip injury and related complications including the ongoing treatment of his post surgical infection. Petitioner has been unable to work since the accident.

Based upon the record as a whole and the Arbitrator's finding with respect to Accident, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his current condition of ill being is causally connected to the accidental injury sustained on August 4, 2016.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, Petitioner's condition of ill being in the left hip and related complications including the ongoing treatment of his post surgical infection are causally connected to the accident. Petitioner is entitled to payment for reasonable and necessary treatment related to that condition.

Petitioner admitted extensive treating medical records documenting the care he has received. The Arbitrator finds the treatment documented in the medical records is reasonable, necessary and causally connected to the accident. Petitioner admitted PX 3 and PX 9 with respect to the medical bills incurred. The first page of the exhibit is a cover spreadsheet prepared by counsel listing certain charges and dates of service. However, the remainder of the document does not support this cover sheet. It contains some charges not listed on the cover sheet, is missing much of the charges claimed on the cover sheet, and includes additional incomprehensible spreadsheets which appear to be the processing of bills by the health insurance carrier. The bills that do exist further document extensive payments by Blue Cross/Blue Shield as testified to by Petitioner. The cover sheet does not include reductions for these payments or adjustments.

Based upon the documents submitted, the Arbitrator is unable to provide a definitive figure of what bills are owed beyond addressing which treatment is reasonable, necessary and causally connected and noting that Respondent is responsible for payment of any unpaid bills for the charges incurred for that treatment and to hold Petitioner harmless for the payments made by Blue Cross/Blue Shield.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds Respondent shall pay for reasonable and necessary medical services, pursuant to the medical fee schedule, for Petitioner's condition of ill being in the left hip and related

complications including his post surgical infection, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical benefits that have been paid pursuant to a group medical plan under Section 8(j), 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 support of the Arbitrator's decision with respect to (K) Prospective Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, Petitioner's condition of ill being in the left hip and related complications including the ongoing treatment of his post surgical infection are causally connected to the accident. Petitioner is entitled to payment for reasonable and necessary treatment related to that condition. The undisputed medical records document that, as of the date of hearing, Petitioner was still under active medical care for the condition of ill being in his left hip. He was still disabled and in need of further follow up including therapy and follow up visits related to his surgical hip replacement and monitoring of the post operative infection. His treatment is being coordinated by Dr. Moe and Dr. Noor.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Respondent shall authorize and pay for additional reasonable and necessary treatment to the left hip and leg or complications related thereto consistent the recommendations of Dr. Moe or Dr. Noor.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, Petitioner is entitled to temporary total disability for periods that he is unable to work as a result of his condition of ill being in the left hip and leg and related complications including the post operative infection. The Petitioner has been totally disabled by his treating physicians from the date of the accident through the date of hearing in this matter and remains under active medical care. Petitioner admitted a work status note taking Petitioner off work beginning April 7, 2017 for the next two months, beyond the date proofs were closed on May 3, 2017.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for a period of 39 weeks, commencing August 5, 2016 through May 3, 2017, being the date of hearing in this matter, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $1,500.00 for TTD paid.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICE TURNER,

Petitioner,

vs. NO: 15 WC 42052

CATERPILLAR, INC.,

Respondent.

18IWCC0432

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) of the Act having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, TTD and prospective medical treatment 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Decision of the Arbitrator is reversed to clarify the disputed issues of accident and causal connection. The Conclusions of Law indicated accident to be a disputed issue but did not directly address it. It was indicated the "Arbitrator concludes that Petitioner's current condition of ill-being is not related to repetitive trauma arising out of and in the course of her employment . . .." From this passage, it is unclear if the Arbitrator found that a compensable accident in the form of repetitive trauma had occurred but that causal connection between the repetitive trauma and Petitioner's current condition of ill-being was not shown to be causally related or, alternatively, that both accident and causal connection went unproven with the Arbitrator only referencing the latter. Based on the Arbitrator's addressing the issue of causal connection, the

Commission concludes the Arbitrator found Petitioner did, in fact, sustain an accidental injury in the form of repetitive trauma that arose out of and in the course of her employment for Respondent that manifested itself on August 31, 2015, and, thus, necessitated the discussion of whether a causal connection existed between Petitioner's current condition of ill-being and her employment. Alternatively, the Commission, itself, finds as such with respect to the occurrence of a compensable accident.

The Arbitrator denied Petitioner any compensation under the Act after concluding that Petitioner's current condition of ill-being was unrelated to any repetitive trauma arising out of and in the course of her employment with Respondent and manifested itself on August 31, 2015. In so concluding, the Arbitrator found the weights Petitioner handled were "substantially" less than what she had testified to. The Arbitrator also found Respondent's testifying physicians, including Respondent's clinic physician, Dr. Lawrence Splitter, to be more persuasive that Dr. Lawrence Li, Petitioner's examining physician. The Commission places more credence in Petitioner's medical records than did the Arbitrator, and those records, when considered in conjunction with Petitioner's work activities, leads the Commission to find that Petitioner's work activities resulted in her experiencing an accident that arose out of and in the course of her employment and were the cause of the current condition of ill-being of her left elbow.

The Commission finds Petitioner's initial medical records imply the presence of cubital tunnel syndrome and last few medical records confirm this but also finds these records were seemingly ignored by Dr. Splitter and, subsequently, by the Arbitrator. On September 3, 2015, Petitioner presented to a Dr. Just, then a physician in Respondent's clinic, with complaints of experiencing a tingling sensation to all five digits in her left hand after working 20 minutes. After an examination conducted by Dr. Just, Petitioner was diagnosed as having left wrist and hand tingling of an unknown origin. Dr. Just was seen again on September 24, 2015, and, at that time, Petitioner complained to him of now having numbness in both hands. Dr. Just modified his diagnosis to now indicate that both of Petitioner's hands experienced tingling. Petitioner came to undergo an electrodiagnostic examination on December 3, 2015, that resulted in findings of mild bilateral median neuropathy at the wrists and mild bilateral ulnar neuropathy at the elbows. The Commission finds Petitioner presented to Respondent in September 2015 with symptomology consistent with both carpal tunnel syndrome and cubital tunnel syndrome and the electrodiagnostic examination confirming both being present about Petitioner's wrists and elbows at that time. By October 17, 2017, the date of the arbitration hearing, per Petitioner, only the symptoms consistent with left-sided cubital tunnel syndrome persisted.

Sometime after September 24, 2015, Dr. Splitter succeeded Dr. Just as Petitioner's clinic physician and, on October 21, 2015, first examined Petitioner. Dr. Splitter, on that day, took from Petitioner complaints of pain and tingling in both hands. Dr. Splitter's handwritten examination notes indicate that at least one cubital tunnel was examined, but his findings related to that examination is unknown because Dr. Splitter's handwriting was indecipherable. Dr. Splitter did, however, diagnosis Petitioner with bilateral hand tingling. The diagnosis did not distinguish as to which, in any, particular fingers tingled. According, the Commission is left to

presume that all five fingers on both hands tingled on the day Dr. Splitter first examined Petitioner.

The Commission finds the evidence deposition testimony Dr. Splitter provided on June 1, 2017, to be enlightening about the treatment he provided Petitioner. With respect to the October 21, 2015, examination of Petitioner. He testified that Petitioner demonstrated a negative Tinel's sign at the cubital tunnel but also that he was unsure if he examined both of Petitioner's elbows. The Commission takes notice of Dr. Splitter's testimony implied only one of Petitioner's cubital tunnels was examined and concludes, absent to evidence to the contrary, that only one cubital tunnel was examined on October 21, 2015.

Dr. Splitter's testimony was also notable in that he stated that he did not examine Petitioner's elbows on subsequent examinations because most of her complaints were in the medial nerve distribution. His testimony infers that Petitioner's complaints that were not in the medial nerve distribution were ignored, despite Dr. Splitter's initial diagnosis on October 21, 2015, of Petitioner having bilateral tingling in her hands.

The most telling example of Dr. Splitter's fixation upon Petitioner's condition of bilateral carpal tunnel syndrome at the expense of her condition of bilateral cubital tunnel syndrome is found in Dr. Splitter's recitation of the December 3, 2015, electrodiagnostic examination results. On January 7, 2016, Dr. Splitter wrote of the electrodiagnostic examination showing bilateral carpal tunnel syndrome. He failed to reference that the same examination also showed bilateral cubital tunnel syndrome.

Dr. Splitter's treatment of Petitioner was myopically focused upon Petitioner's condition of bilateral carpal tunnel syndrome despite Petitioner's complaints and his own examinations suggesting and the diagnostic test revealing Petitioner also had bilateral cubital tunnel syndrome. Dr. Splitter's opinions, therefore, are given little, if any, weight.

Respondent supplemented its clinic records and Dr. Splitter's testimony with an independent medical examination report written by and an evidence deposition testimony given by Dr. Sam Biafora. He concluded that Petitioner's cubital tunnel syndrome symptomology and positive diagnostic findings were related to her sleeping with bent elbows and not her work activities. He did not find Petitioner's work activities required her to have forceful and repetitive gripping or sustained extreme flexion involving her elbows to result in cubital tunnel syndrome.

Dr. Biafora's testimony primarily focused on biomechanics and, specifically, the ratio of force to angle necessary to cause compression of the ulnar nerve in the elbow. The takeaway from his testimony is the greater the force the less of an angle is needed to compress and aggravate the ulnar nerve. He testified that force applied to an elbow flexed to 110° would result in the ulnar nerve becoming irritated within a short period of time. He concluded someone handling between 15 and 30 pounds over a seven-hour work shift with elbows held at 90° would not be an activity that would result in cubital tunnel syndrome. Dr. Biafora testified that

Petitioner demonstrated to him the degree to which she flexed her elbows when performing her work activities and that the demonstrated activity would have been insufficient to result in cubital tunnel syndrome.

Dr. Biafora's causal connection opinion is compromised to a degree by his testimony that there is some compression and stretching of the ulnar nerve with the elbow held at 90°. Such compression and stretching would seem to occur with elbows without any force being applied. The effect of adding force upon the elbow, in Petitioner's case, from ounces up to 50 pounds, would seem to, resultantly, compound the compression and stretching of the ulnar nerve to varying degrees. Assuming *arguendo* that Petitioner's work activities did not cause her cubital tunnel syndrome, as posited by Dr. Biafora, it may have contributed to it as Dr. Li suggested.

To Dr. Li, the force placed upon Petitioner's ulnar nerves was not as important to him than was the repeated flexion of the elbow that came with Petitioner performing her work activities. Dr. Li echoed Dr. Biafora's claim that flexing the elbow places tension on the ulnar nerve and indicated 60° is the threshold as to when pressure across the ulnar nerve increases.

Dr. Li testified that the predominant cause of ulnar neuropathy of the elbow is the repeated or constant flexion of the elbow. He opined that Petitioner bending her elbow 700 times per shift would be significant. He was less concerned about the weight handled by bent elbows.

The Commission, relying on the statements of both Dr. Biafora and Dr. Li, that there is at least some compression with the elbows held at 90°, concludes that any force in the form of weight will result in further compression of the ulnar nerves in the elbow and further stretching of the ulnar nerve when the elbow is flexed. Based on the histories and medical opinions, Petitioner's ulnar nerve in her left ulnar nerve either became symptomatic due to the way that she slept and was made worse by her work activities or became symptomatic directly as a result of her work activities. In the context of a workers' compensation claim, an "[a]ccidental injury need not be the sole causative factor, nor even the primary causative factor, as long it was *a* causative factor in the resulting condition of ill-being." (Emphasis in the original). Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205, 797 N.E.2d 665, 673, 278 Ill.Dec. 70 (2003).

The Commission, relying on the medical records of Dr. Just, Dr. Splitter, and Dr. Gregory Adamson, Petitioner's treating physician, as much as if not more than Petitioner's testimony, finds Petitioner sustained repetitive trauma to her wrists bilaterally and her elbows bilaterally that arose of and in the course of her employment as a materials specialist for Respondent and resulted in her developing bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. Those same medical records indicate Petitioner's bilateral carpal tunnel syndrome and her right-sided cubital syndrome resolved over time and with non-surgical intervention but that her left-sided cubital tunnel syndrome symptomology continues to persist.

Dr. Adamson, on September 2, 2016, after reviewing the results of the repeat electrodiagnostic test performed upon Petitioner on August 26, 2016, concluded the most

appropriate course of treatment for Petitioner to be a left ulnar nerve decompression/transposition at the elbow as the test revealed continued left cubital tunnel syndrome. Dr. Li concurred with the recommended treatment. The Commission, finding both accident and a causal connection between the condition of Petitioner's left elbow and her work activities, finds the recommended surgery to be causally related to her accident.

Petitioner also seeks seven days of benefits under Section 8(a) of the Act, claiming that she was temporarily totally disabled from November 4, 2015, through November 10, 2015. The Commission, in reviewing the evidentiary record, cannot find evidence that Petitioner was so disabled November 4, 2015, through November 10, 2015.

Petitioner presented to Dr. Adamson on November 4, 2015, for an initial evaluation of her condition. Dr. Adamson provided Petitioner with two return-to-work prescriptions that day. One restricted Petitioner's ability to work on that day only, limiting her only to light duty. The second allowed Petitioner to return to work the following day, November 5, 2015, without restrictions. In a letter by Dr. Adamson to Dr. Splitter on November 5, 2015, he wrote that Petitioner requested her being released to work without having no specific restrictions out of concern that she would be not allowed to work. Dr. Adamson, in the letter, wrote that having Petitioner return to work without a restriction was reasonable.

Petitioner offered testimony with respect to her treatment with Dr. Adamson. She noted that she treated with him from November 2015 through September 2016 and that Dr. Adamson had her undergo repeat electrodiagnostic testing as well as injections and had prescribed wrist splints for her. She did not testify that Dr. Adamson took her off work at any time. Furthermore, her not working from November 4, 2015, through November 10, 2015, is absent from her testimony.

Petitioner, at most, would have been found to be temporarily totally disabled for one day, November 4, 2015, if she had shown that Respondent was unable or unwilling to accommodate the light duty restrictions imposed upon her by Dr. Adamson. No such showing was made.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the treatment recommended by Dr. Gregory Adamson, a left ulnar nerve decompression/transposition, as well as all reasonable and necessary subsequent medical care related to said treatment.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is not entitled to temporary total disability benefits as contemplated under Section 8(b) of the Act but this denial shall, in no instance, be a bar to a further hearing and determination of any future award of temporary total disability compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of

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expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

DATED: JUL 13 2018
KWL/mav
O: 05/14/18
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Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

TURNER, PATRICE
Employee/Petitioner

Case# **15WC042052**

CATERPILLAR INC
Employer/Respondent

18IWCC0432

On 11/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% 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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-4340

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)

Patrice Turner
Employee/Petitioner

v.

Caterpillar, Inc.
Employer/Respondent

Case # 15 WC 42052

Consolidated cases: n/a

18IWCC0432

An *Application for Adjustment 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 October 17, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, August 31, 2015, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $29,254.16; the average weekly wage was $562.58.

On the date of accident, Petitioner was 26 years of age, single with 2 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 $107.18 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $107.18.

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, 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

William R. Gallagher, Arbitrator
ICArbDec19(b)

November 18, 2017
Date

NOV 27 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of "on or about 09/01/15" and that Petitioner sustained "cummulative trauma" to "bilateral hands" (Petitioner's Exhibit 4). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

As noted herein, the date of accident (manifestation) was, in fact, August 31, 2015. Further, the prospective medical treatment sought by Petitioner was for Respondent to authorize and pay for left cubital tunnel surgery.

Petitioner worked for Respondent from September 22, 2014, through December 7, 2015, as a materials specialist. Petitioner's primary job duty was to pick up parts from one bin to put them into another to fill orders. Petitioner began working in an area called line 76. When Petitioner worked in line 76, she wore a headset called "Jennifer" which gave her instructions on where to go, what parts needed to be picked up and how many to pick. Petitioner estimated the weight of the parts she lifted/moved in line 76 varied from one pound to 40 pounds with the average part weighing 15 pounds. Petitioner stated she usually used both of her arms when picking parts in line 76. When Petitioner bent down to pick up a part, she testified both of her elbows were at a 90° angle.

In August, 2015, Petitioner was transferred to another area called line 77. Petitioner's job duties in line 77 were essentially the same as they were in line 76; however, Petitioner stated that the parts weighed more in line 77 than they did in line 76. She stated the parts in line 77 weighed from 15 pounds to 50 pounds. Petitioner continued to use both arms when picking up the parts; however, Petitioner used her left arm more than her right arm because of the configuration of her workstation. While working in line 77, Petitioner did not wear a headset, but got her directions from a computer screen. Petitioner stated that when she moved parts in line 77, she usually had her elbows at a 90° angle.

On cross-examination, Petitioner agreed that she would have moved parts that weighed less than one pound in line 76 because some of the parts were very small, such as washers. In line 77, Petitioner stated that she never had occasion to move parts that weighed less than one pound.

Respondent tendered into evidence a record which purportedly contained all of the parts Petitioner picked from July 8, 2015, through August 31, 2015. In line 76, the record of the parts of Petitioner picked would be recorded either through "Jennifer" or with a scanner gun. In line 77, Petitioner would enter the parts and quantity on the computer screen. Petitioner acknowledged that the exhibit contained her employee ID number and that it was a record of the parts she scanned; however, Petitioner did not know if it contained all of the parts she picked up and scanned (Respondent's Exhibit 5).

Dustin Wagoner, Respondent's safety/security manager, testified when this case was tried. Wagoner was knowledgeable about the job duties and workstations in both line 76 and line 77. In both lines, the employee would obtain parts from a container and place them either in a shipping box or into a tote where they would go to another department.

Wagoner also identified and authenticated as a business record Respondent's exhibit which identified the parts Petitioner picked between July 8, 2015, and August 31, 2015. On the right side of the document, it identified the number and type of part as well as its aggregate weight. The Petitioner's employee ID number was on the left side of the document. Wagoner testified that the data is collected for variety of purposes, namely, inventory, tracking of employee's speed, error rates, etc., and not just for purpose of litigation. Wagoner said he obtained the data for the dates indicated at the request of Respondent's counsel. He testified that the data collected was in the regular course of Respondent's business (Respondent's Exhibit 5).

Given Petitioner's testimony as to when she worked in line 76 and line 77, the data contained in Respondent's Exhibit 5 would encompass the end of her time in line 76 and the beginning of her time in line 77. The number of parts Petitioner picked varied considerably. On July 16, 2015, Petitioner only picked 10 parts, but on August 17, 2015, she picked 4,392 parts. In regard to the aggregate weight of the parts, during the period beginning July 8, 2015, (while in line 76) Petitioner picked 108 parts that weighed more than one pound and 4,588 parts that weighed less than one pound. During the month of August, 2015 (while in line 77) Petitioner picked 11,040 parts that weighed more than one pound and 114,743 parts that weighed less than one pound (Respondent's Exhibit 5).

Petitioner initially sought medical treatment at Respondent's medical department on September 1, 2015. At that time, Petitioner stated she had numbness/tingling in her left thumb and wrist and provided an incident date of August 31, 2015 (the date of manifestation alleged in the stipulation). On September 3, 2015, Petitioner was evaluated by Dr. Just, the plant physician. Petitioner informed Dr. Just she had to move parts the weighed up to 50 pounds. Dr. Just's examination of Petitioner's left hand was normal, but she recommended the use of a wrist splint at night (Respondent's Exhibit 1).

Dr. Just subsequently saw Petitioner on September 24, 2015. At that time, Petitioner complained of symptoms in both hands. Dr. Just's examination of Petitioner's left and right hands was normal and she again recommended the use of night splints (Respondent's Exhibit 1).

Petitioner was evaluated by Dr. Lawrence Splitter, the plant physician (Dr. Just had apparently left the employment of Respondent) on October 22, 2015. Dr. Splitter suspected that Petitioner had left carpal tunnel syndrome and he referred her to Dr. Gregory Adamson, a hand surgeon (Respondent's Exhibit 1).

Dr. Adamson saw Petitioner on November 4, 2015. At that time, Petitioner complained of numbness/tingling in both hands since September, 2015. Dr. Adamson's findings on examination suggested that Petitioner had left carpal tunnel syndrome. He referred her to Dr. Frank Russo for EMG/nerve conduction studies (Petitioner's Exhibit 1).

Petitioner was seen by Dr. Splitter on November 11, 2015. Petitioner still had complaints of numbness/tingling in her left hand. On examination, Dr. Splitter noted a positive Phalen's test of the left wrist (Respondent's Exhibit 1).

Dr. Russo saw Petitioner on December 3, 2015, and performed EMG/nerve conduction studies at that time. Dr. Russo opined that the studies were positive for mild bilateral median neuropathy at the wrists and mild bilateral ulnar nerve neuropathy at the elbows (Petitioner's Exhibit 1).

Petitioner was seen by Dr. Splitter on December 7, 2015, and he noted that she had undergone EMG/nerve conduction studies but did not know the results (Respondent's Exhibit 1). On that same day, Petitioner's employment was terminated by Respondent.

Even though Petitioner's employment with Respondent had terminated on December 7, 2015, she was again seen by Dr. Splitter on January 7, 2016. He noted she was continuing to be seen by Dr. Adamson. He noted that Dr. Adamson had diagnosed Petitioner with bilateral carpal tunnel syndrome. [The Arbitrator noted the Dr. Adamson had previously stated the findings suggested Petitioner had bilateral carpal tunnel syndrome, but he noted the actual diagnosis on January 8, 2016.]

Petitioner was again seen by Dr. Adamson on January 8, 2016. At that time, he opined she had bilateral carpal tunnel syndrome and De Quervain's (Petitioner's Exhibit 1).

In Dr. Splitter's subsequent review of his records on January 14, 2016, he observed Petitioner had the additional diagnosis of De Quervain's. Dr. Splitter noted this diagnosis was not made prior to Respondent's having terminated Petitioner's employment (Respondent's Exhibit 1).

Petitioner continued to be seen by Dr. Adamson who ordered repeat EMG/nerve conduction studies which were performed by Dr. Glenn Cheng on August 26, 2016. The studies were positive for left cubital tunnel syndrome, borderline right cubital tunnel syndrome and mild right ulnar entrapment of the wrist. Dr. Adamson saw Petitioner on September 2, 2016, and reviewed the diagnostic studies. He opined Petitioner had bilateral cubital tunnel syndrome, greater on the left than right. At that time, Dr. Adamson made a recommendation that Petitioner undergo left cubital tunnel surgery (Petitioner's Exhibit 1).

At the direction of Respondent, Petitioner was examined by Dr. Sam Biafora, a hand/upper extremity surgeon, on November 17, 2016. In connection with his examination of Petitioner, Dr. Biafora reviewed medical records as well as the "Employee Incident Report" provided to him by Respondent. Dr. Biafora agreed that Petitioner had left cubital tunnel syndrome, but that there was no current diagnostic evidence of left carpal tunnel syndrome. He agreed that the surgical recommendation made by Dr. Adamson was appropriate; however, he opined that Petitioner's left cubital tunnel syndrome was not work-related. He based this opinion upon his understanding that Petitioner's work for Respondent did not require forceful or sustained extremes of flexion of the elbow for prolonged periods of time while at work (Respondent's Exhibit 3; Deposition Exhibit 2).

Dr. Biafora prepared a supplemental report dated February 3, 2017. In that report, he stated that neither Petitioner's right cubital tunnel syndrome nor right carpal tunnel syndrome were related to Petitioner's work activities for Respondent (Respondent's Exhibit 3; Deposition Exhibit 3).

At the direction of her counsel. Petitioner was examined by Dr. Lawrence Li. an orthopedic surgeon. on April 17. 2017. In connection with his examination of Petitioner, Dr. Li reviewed medical records provided to him by Petitioner's counsel. When seen by Dr. Li. Petitioner informed him she had picked parts that weighed between 23 to 49 pounds and placed them in totes. Dr. Li opined Petitioner had bilateral cubital tunnel syndrome, left much worse than right, and Dr. Adamson's surgical recommendation was appropriate. In regard to causality, Dr. Li opined that because Petitioner had to pick up parts three times a minute and transfer them with her elbows and 90° or more that her elbow complaints were work-related (Petitioner's Exhibit 2).

Dr. Splitter was deposed on June 1, 2017, and his deposition testimony was received into evidence at trial. Dr. Splitter's testimony was consistent with the medical records. Dr. Splitter testified that Petitioner's cubital tunnel and De Quervain's were not work-related because the symptoms that corresponded to them were not noted until after Petitioner's employment with Respondent was terminated (Respondent's Exhibit 2; p 21).

Dr. Li was deposed on July 10, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Li's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Li specifically noted that Petitioner informed him that she picked parts that weighed 23 to 49 pounds and would do so about three times every minute. Dr. Li diagnosed Petitioner with bilateral cubital tunnel syndrome, left worst than right, but found no evidence of carpal tunnel syndrome (Petitioner's Exhibit 2; pp 8-13).
In regard to causality, Dr. Li explained his basis for finding that there was a causal relationship between Petitioner's work activities and her bilateral cubital tunnel syndrome condition. Dr. Li testified Petitioner having to bend over while bending her elbows to pick up parts and transfer them 700 times per shift would be sufficiently repetitive to cause cubital tunnel syndrome (Petitioner's Exhibit 2; pp 17-19).

On cross-examination, Dr. Li stated that the weight of the parts Petitioner had to pick up would not matter. However, when questioned further, he stated that if the part only weighed a few ounces, it would not matter. On further questioning, Dr. Li suggested that lifting parts that weighed between five and six pounds while flexing the elbow probably would matter (Petitioner's Exhibit 2; pp 24-27).

Dr. Biafora was deposed on August 2, 2014, and his deposition testimony was received into our trial. On direct examination, Dr. Biafora's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Dr. Biafora testified that none of Petitioner's upper extremity conditions were work-related. In regard to the cubital tunnel syndrome, Dr. Biafora noted that Petitioner's work did not require her to repetitively and forcefully hyperflex her elbow. In regard to carpal tunnel syndrome, Dr. Biafora noted that Petitioner's lifting would not cause compression of the nerve such as forceful gripping or using a vibratory tool (Respondent's Exhibit 3; pp 14-19).

Subsequent to Petitioner's employment being terminated by Respondent, she returned to work in November, 2016, for a "seasoning company," where she filled packages with various spices/seasonings. She only worked there for approximately one month and then began working for a company that supplies parts to Respondent. Petitioner works in the production of these parts which are very small ones, such as washers. Petitioner still has left elbow symptoms and wants to proceed with the surgery as recommended by Dr. Adamson.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's current condition of ill-being is not related to repetitive trauma arising out of and in the course of her employment for Respondent that manifested itself on August 31, 2015.

In support of this conclusion the Arbitrator notes the following:

The testimony of both Petitioner and Wagoner was consistent in regard to Petitioner's job duties of picking up and moving parts. It was the physical demands of Petitioner's job duties, in particular, the weight of the objects Petitioner had to pick up and move that was disputed.

Petitioner's testimony that the parts she picked up and moved in line 76 weighed one pound 40 pounds and the parts she picked up and moved in line 77 weighed 15 to 50 pounds is not supported by the documentary evidence.

The data tendered into evidence by Respondent of the parts moved by Petitioner from July 8, 2015, through August 31, 2015, clearly showed that, for the most part, the parts Petitioner typically picked up and moved weighed substantially less than what she testified to.

Respondent's plant physician, Dr. Splitter, and Respondent's Section 12 examiner, Dr. Biafora, both opined Petitioner's upper extremity conditions were not work-related.

While Petitioner's Section 12 examiner, Dr. Li, opined that Petitioner's left and right cubital tunnel syndrome conditions were work-related, his opinion was based, to a large extent, upon the in inaccurate belief that Petitioner had to typically pick up objects weighed 23 to 49 pounds.

Given the preceding, the Arbitrator finds the opinions of Dr. Splitter and Dr. Biafora to be more persuasive than that of Dr. Li in regard to causality.

In regard to disputed issues (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES BOCK,

Petitioner,

vs. NO: 12 WC 23949

GENERAL DYNAMICS,

18IWCC0433

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of jurisdiction, accident, medical treatment and expenses, wages, TTD, and PPD and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, in part, and reverses the Decision of the Arbitrator, in part, as stated below. The Decision of the Arbitrator is attached hereto and made a part hereof,

The Commission finds the description of the work activities of Petitioner as written in the Decision of the Arbitrator comports with Petitioner's testimony concerning the same. From this, it is learned Petitioner performed manual labor that involves both his hands and arms as an adjustor operator for Respondent on the claimed date of accident, March 13, 2010.

The Arbitrator found that "Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment on March 13, 2010." The Arbitrator, in so finding, concluded that Petitioner did not demonstrate the claimed injuries to his left wrist and left shoulder were sustained as a result of the work activities he performed for Respondent. The Commission concurs with the findings of the Arbitrator with respect to Petitioner's claim involving his left wrist but disagrees with the findings of the Arbitrator with respect to Petitioner's claim involving his left shoulder.

Petitioner's medical records concerning his left wrist show findings of swelling and a

ganglion cyst to the radial side of the left wrist and evidence of Kienbock's disease as well as vascular disease affecting the small finger on Petitioner's left hand. Tests conducted for ulnar carpal impaction or TFCC tenderness were negative. These findings were made from March 12, 2010, through April 26, 2010, and by physicians secured by both Petitioner and Respondent. Only one of the physicians, Dr. Richard Howard, who examined Petitioner at Respondent's request, alluded to a possible work component to Petitioner's complaints, opining that Petitioner's vascular disease, though caused by Petitioner's smoking, could have been temporarily aggravated by Petitioner's repetitive gripping at work.

On May 10, 2010, Petitioner was seen by Dr. Michael Workman, his primary care physician and one of the physicians whom he had previously seen for his left wrist. During that visit, Petitioner complained of left wrist pain and increased swelling after riding a tractor a few days earlier. MRIs were taken of Petitioner's left wrist that, though of limited diagnostic quality, revealed swelling along the distal ulna. Dr. Workman referred Petitioner to Dr. Angela Freehill who, in turn, referred Petitioner to Dr. Joon Ahn for an examination of Petitioner's left wrist.

Petitioner was seen by Dr. Ahn on June 14, 2010, and Dr. Ahn had Petitioner undergo x-rays of his left wrist. The x-rays revealed a cystic lesion in the lunate area of the ulna area consistent with ulnar impaction syndrome. The examination conducted by Dr. Ahn included an ulnar impaction test. The test resulted in a positive finding and led Dr. Ahn to diagnosis Petitioner with ulnar impaction syndrome and a degenerative TFCC tear. Dr. Ahn testified that these findings were chronic in nature and might have only been revealed after a trauma.

The Commission, after reviewing the evidence, concludes Petitioner experienced two distinct events that involved his left wrist with neither event being related to his employment with Respondent. The first was the manifestation of a ganglion cyst, the Kienbock's disease, and the vascular disease in rapid succession. No medical opinion was offered that connected these conditions tangentially to his work activities. Dr. Howard, Respondent's Section 12 examiner, indicated that he was unable to connect the ganglion cyst to Petitioner's work activities and only suggested that the numbness caused by the vascular disease in Petitioner's hand could have been temporarily aggravated by Petitioner engaging in repetitive gripping.

The second event occurred sometime after his left wrist was examined on April 26, 2010, and resulted in swelling at the distal left ulna and diagnoses of ulnar impaction syndrome and degenerative TFCC tear. None of these conditions had been found prior to April 26, 2010. Petitioner's medical records before that date noted the swelling only to the radial side of the left wrist and repeated tests were negative for ulnar impaction syndrome or any tenderness about the TFCC. The sudden onset of the TFCC tear and the ulnar impaction syndrome undermines Dr. Ahn's speculative comment about years of constant, repetitive, twisting motion of the wrist being a possible contributing factor to the condition of Petitioner's left wrist but strengthens the likelihood that Dr. Ahn's comment about a traumatic event being a probable contributing factor is correct, particularly with Petitioner's stated hobby being fighting.

The same medical records the Commission relies upon to find Petitioner's left wrist complaints are not the result of an accident that arose out of and in the course of his employment are the same medical records the Commission relies upon to find Petitioner's left shoulder

complaints are the result of an accident that arose out of and in the course of his employment with Respondent.

Petitioner, per his testimony, made complaints about his left arm to Todd Hawkins his supervisor, prior to seeing Dr. Workman on March 26, 2010. Dr. Workman recorded Petitioner's complained of pain in the left upper arm with motion. For reasons unknown, Dr. Workman's examination on that day focused exclusively on Petitioner's left wrist.

Petitioner, pursuant to a referral by Dr. Workman, was seen by Dr. Robert Golz, also on March 26, 2010. Petitioner's chief complaint was noted to concern his left upper extremity but, as with his appointment with Dr. Workman earlier that day, no examination of Petitioner's left shoulder took place. Again for reasons unexplained, the sole focus of the visit was on Petitioner's left wrist.

On some unknown date, Dr. Workman ordered Petitioner to undergo an MRI of his left shoulder and, on May 15, 2010, Petitioner underwent the MRI at Herrin Hospital. The MRI revealed mild left acromioclavicular joint arthrosis, moderate rotator cuff tendinosis, no full thickness rotator cuff tear, and trace fluid about the subacromial/subdeltoid bursa. The indication for this examination was given as left shoulder pain due to an injury to the left shoulder three months ago at work. On the basis of the MRI, Dr. Workman referred Petitioner to Dr.Angela Freehill.

Dr. Freehill conducted an evaluation of Petitioner's left shoulder on June 8, 2010, and concluded, after conducting range of motion tests upon Petitioner's left shoulder, that Petitioner demonstrated left shoulder impingement. She ordered Petitioner to undergo physical therapy and prescribed anti-inflammatories.

Petitioner returned to Dr. Freehill on July 20, 2010. He had not undergone the prescribed physical therapy but performed self-directed exercises at home. His left shoulder continued to be impinged despite the exercises. A cortisone injection was administered, and Dr. Freehill again ordered Petitioner to undergo physical therapy and continued him on anti-inflammatory medication.

Dr. Freehill ordered surgical intervention to address Petitioner's continuing left shoulder pain and impingement on August 24, 2010. Petitioner obtained no lasting relief despite undertaking physical therapy and injection therapy as well as anti-inflammatory medication. A left shoulder arthroscopy and subacromial decompression was performed on August 30, 2010.

Approximately one week after the surgery, on September 7, 2010, Petitioner returned to Dr. Freehill and informed her that he no longer needed pain medication. Dr. Freehill ordered post-operative physical therapy. Sixteen weeks later, on January 14, 2011, Petitioner reported that he had no problem with his shoulder and that he could do anything that he wanted. He believed himself ready to resume working and Dr. Freehill removed all restrictions upon his ability to work, allowing him to return to work the following Monday with instructions to return as needed. Petitioner never returned to Dr. Freehill.

The Commission disagrees with the findings of the Arbitrator. The Arbitrator concluded that Petitioner's work activities were unrelated to his work activities, in part, because of the opinions expressed by Dr. Mitchell Rotman, Respondent's Section 12 examining physician.

Dr. Rotman's opinions were formed after his review of Petitioner's medical records. He found that the first documentation of left shoulder pain was a month-and-a-half after Petitioner was taken off work to address complaints of left wrist pain. He also viewed video footage of Petitioner's work activities performed by an unknown employee of Respondent. The Commission finds Dr. Rotman's opinion with respect to the former to be factually wrong and, with respect to the latter, unpersuasive.

As noted by Dr. Rotman, Petitioner was taken off work on March 12, 2010, by Dr. Workman due to complaints concerning his left wrist. Twelve days later, on March 24, 2010, Petitioner returned to Dr. Workman with additional complaints concerning pain upon motion of the left upper arm. Dr. Workman, for reasons unknown, did not address those complaints through a physical examination of Petitioner's left shoulder. The Commission cannot hold Dr. Workman's failure to address that complaint against Petitioner. It was documented that Petitioner made it known to Dr. Workman that he had pain with use of his left shoulder. Dr. Workman, despite recording it, ignored it. Dr. Rotman, in reviewing Petitioner's medical records, ignored it. The Arbitrator, relying on Dr. Rotman's opinion, ignored it. The Commission cannot.

The Commission finds the complaint of "pain with range of motion" made to Dr. Workman on March 24, 2010, sufficient to suggest a malady in Petitioner's shoulder. Again, for reasons unknown, Dr. Workman focused exclusively on Petitioner's left wrist.

Dr. Rotman's as-testified-to causal connection opinion, after watching the video of Petitioner's work activities, is found to be underwhelming and somewhat contradictory. He testified that the video demonstrated only a few activities that were performed at shoulder level and none that were done repetitively. On cross examination, he acknowledged that activity of lifting shells out of a box at shoulder level, if done repeatedly, could cause symptoms in someone with impingement in the shoulder. The Commission, in revisiting Petitioner's arbitration hearing testimony, found Petitioner testified to grabbing one 85-pound belt after another with only two fifteen-minute breaks and a half-hour lunch break over the course of his work shift. The Commission finds Petitioner's uncontradicted testimony about his work environment and work activities to be more credible than Dr. Rotman's interpretation of Petitioner's work activities. Dr. Rotman's causal connection opinion is given no weight.

The Arbitrator also references an examination of Petitioner conducted by Dr. Richard Howard, one of Respondent's Section 12 examining physicians and concludes that the report that followed the examination documented a normal shoulder exam. This assertion is inaccurate. Dr. Howard, on April 26, 2010, did not conduct an examination of Petitioner's shoulder *per se.* The foci of the Section 12 examination conducted by Dr. Howard was Petitioner's right elbow and left wrist as those were the areas of primary concern to Petitioner, per Dr. Howard's Section 12 examination report.

As it relates to Petitioner's shoulder, Dr. Howard's report is, at best, incomplete. The report indicates, "Shoulder has full range of motion with no weakness or tenderness in any plane." No indication is given within the report as to which shoulder was examined. No other reference is made to either of Petitioner's shoulders.

The Commission finds the only aspect of Dr. Howard's report that can be construed against Petitioner's claimed injury to his left shoulder is the absence of any recordation of him complaining about any symptomology involving his left shoulder. The Commission does note, however, as recorded by Dr. Howard, Petitioner's principal complaints concerned his right elbow and left wrist.

Petitioner's left shoulder, as can be concluded by his testimony and the medical records and testimony of medical professionals, sustained injuries due to the repetitive nature of his employment, specifically the continuous handling of 85-pound belts at about shoulder level. The medical treatment, surgical intervention, and physical therapy that Petitioner received were necessary to remedy those injuries.

The injuries to Petitioner's left shoulder, in addition to necessitating medical treatment, rendered him temporarily totally disabled from July 20, 2010, through January 14, 2011. Dr. Freehill regularly prescribed that Petitioner to remain off work due to his left shoulder until January 14, 2011. On that day, Petitioner was released back to work without any restrictions.

Petitioner testified, at the time of the arbitration hearing, that he had not, despite the release back to work by Dr. Freehill, and later Dr. Ahn, returned to working in an industrial setting but has not ruled out returning to such work.

It is axiomatic that Petitioner has the burden of proving that the injuries he claimed about his left wrist and left shoulder were due to the repetitive trauma inflicted upon the same due to his work activities. The Commission is convinced he has demonstrated that his left shoulder but not his left wrist was injured due to those work activities and is entitled to compensation under the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $394.60 per week for a period of 25-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $355.14 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 10% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner for medical expenses under §8(a) and §8.2 of the Act related only to treatment of his left shoulder.

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

18IWCC0433

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 $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: JUL 13 2018
KWL/mav
O: 05/14/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BOCK, JAMES
Employee/Petitioner

Case# **12WC023949**

GENERAL DYNAMICS
Employer/Respondent

18IWCC0433

On 7/31/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2269 NEWCOMB LAW OFFICE
PAULA M NEWCOMB
503 PUBLIC SQ PO BOX 753
BENTON, IL 62812

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMES BOCK
Employee/Petitioner

v.

GENERAL DYNAMICS
Employer/Respondent

Case # 12 WC 23949

Consolidated cases: _____

18IWCC0433

An *Application for Adjustment 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 **October 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 13, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,716.62**; the average weekly wage was **$591.90**.

On the date of accident, Petitioner was **45** 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 **$7,929.96** for other benefits, for a total credit of **$7,929.96**.

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment on March 13, 2010. All benefits are hereby denied. All other issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

Signature of Arbitrator

July 25, 2017
Date

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

18IWCC0433

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMES BOCK
Employee/Petitioner

v. Case #: 12 WC 23949

GENERAL DYNAMICS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, 51 years of age and right hand dominant, claims that his work activities for Respondent caused left wrist and left shoulder injuries. He alleges an accident/manifestation date of March 13, 2010. Respondent disputes accident, causation, medical bills, TTD benefits and the nature and extent of the injury.

Petitioner started working for Respondent November 4, 2004. He worked multiple different manual labor jobs that required the use of his arms and hands. Petitioner estimated that half his employment with Respondent was spent working in Link and Pack. Petitioner attributes the left wrist and left shoulder conditions to the work activities in Link and Pack.

Petitioner worked as an adjustor operator on the Link and Pack line. Petitioner's Exhibit P is a diagram Petitioner created that demonstrates the set up of the Link and Pack job. The job is shown in Respondent Exhibit 3, a video. More specifically, video clip 11 demonstrates the process Petitioner testified he primarily performed in Link and Pack.

Petitioner described that a Linker machine fastens bullets into a chain belt. The Linker machine pushes the belt onto the conveyor or product line. Petitioner cuts the belt at 100 bullets when the belt reaches the product line. Each belt is approximately 10 feet long and weighs 85 pounds. After Petitioner cuts the belt, he grabs the belt with his left arm and pulls it in a loop back toward the Linker machine. Petitioner testified that because of his height he had to lean over the conveyor to pull the belt. Petitioner then flips the belt so all the links are facing upward. On occasion, Petitioner would then grab the belt with both arms and put it up on a higher conveyor. The higher conveyor is approximately Petitioner's height of 5 feet 5 inches. Petitioner had assistance on day shift to complete these activities but not night shift. Petitioner processed between 210 and 230 belts per night shift. He had one (1) hour worth of breaks in an eight (8) hour shift.

Respondent's Exhibit 5 lists Petitioner's work hours in each job from March 29, 2009 through March 25, 2010. The Exhibit breaks down Petitioner's work hours between January and March 2010. From January 2010 through March 19, 2010, Petitioner's labor hours totaled 307.7. This is the equivalent of 38 eight hour work days. Of the 307.7 hours, Petitioner worked 159.2 hours in Link and Pack. This is the equivalent of 20 eight hour work days or 4 five day work weeks. RX5.

From March 29, 2009 through December 2009, Petitioner worked 639.30 labor hours (947-307.7). This is the equivalent of approximately 80 eight hour work days. Respondent's Exhibit 5 does not specify the number of hours work in Link and Pack. RX5.

Petitioner testified that around March 15, 2010, he reported to his supervisor Todd Hawkins that his left arm and left wrist hurt. The symptoms had gradually worsened over one to two months. The incident report, signed by Petitioner March 18, 2010, reports a left wrist injury. The nurse documented left wrist swelling. There is no mention of the left shoulder or arm. Petitioner denied any injuries to the left wrist and shoulder outside of work. He denied any injury to the dominant right upper extremity. RX9.

Petitioner saw his primary care physician Dr. Aaron Workman March 12, 2010. He gave a history of left wrist pain for the prior two months with no known injury. There was no mention of shoulder pain. He stated the wrist symptoms increased over the prior month when performing his job activities that involved pulling and flipping belts. Dr. Workman provided Petitioner a splint, ordered wrist x-rays and prescribed naproxen. RX7.

On March 19, 2010, Petitioner saw Dr. Austin at Respondent's request. Petitioner reported radial sided left wrist swelling and numbness in the fourth and fifth fingers. He related the symptoms to flipping belts at work. He denied any outside work or hobbies. On exam, ulnar grind testing for TFCC injury was negative. Tinel's sign at the left wrist and elbow were normal. There was a slight purple discoloration to the distal phalanx of the left little finger. There was evidence of a cyst on the radial or thumb side of the left wrist. There were no left shoulder complaints. Petitioner was already taking Norco for a non-work related injury. RX6.

Dr. Austin's impressions were (1) subacute left wrist extensor ganglion cyst; (2) possible Kienbock's avascular necrosis of lunate bone; and (3) subjective intermittent numbness to distal left fifth finger most likely peripheral vascular deficiencies from smoking. Dr. Austin placed restrictions of right hand work only, continued use of the left wrist brace and follow up with an orthopedist. RX6.

Respondent did not accommodate the restriction, and Petitioner remained off work until January 24, 2011.

Petitioner returned to Dr. Workman March 26, 2010, for left wrist pain. In addition, Petitioner stated his left pinky turned blue after he had been off work a couple days. He had pain and decreased motion in the left upper arm with range of motion. On exam, Petitioner's left pinky was blue and cold. There was no documentation of a left shoulder exam. Plain film x-rays of the left wrist performed at Herrin Hospital showed subtle lunacy in the lunate bone, which

was non-specific but suggestive of subchondral cysts and early Kienbock's disease. Dr. Workman called Dr. Robert Golz to see Petitioner that day. RX7.

Petitioner reported to Dr. Golz that his left wrist symptoms were related to repetitively pulling belts weighing 85 pounds up to 240 times per shift. The pain was localized at the volar radial aspect of the wrist. He reported that his left little finger was constantly cold and painful with occasional numbness and tingling in the left little and ring fingers. A pulse ox testing in the left pinky was initially 73 but then returned to normal. Dr. Golz reviewed the x-rays and felt there were subtle radial lunacies suspicious for Kienbock's disease. He recommended therapy and a left wrist MRI to rule out Kienbock's disease. He referred Petitioner to a vascular surgeon in St. Louis for the left little finger for probable Raynaud's or Buerger's disease. There was no report or exam of the left shoulder. RX8.

On April 7, 2010 Petitioner returned to Dr. Workman and reported that there was no longer blueness or pain the left little finger. He was not working due to the wrist and arm. The assessment was left wrist pain. Dr. Workman recommended follow up with Dr. Golz and the work doctor for the wrist. RX7.

On April 26, 2010, Petitioner was evaluated by Dr. Richard Howard, Respondent's Section 12 examiner. He reported right elbow problems that resolved since he stopped working and left wrist pain and occasional numbness and tingling into the tip of the fifth finger. He gave a consistent history of his work activities. Dr. Howard reviewed the March 12 and 19, 2010, left wrist x-rays as well as the records from Dr. Austin and Dr. Golz. He interpreted the x-rays to show a small cystic change in the ulnar corner of the lunate, consistent with a chronic ulnar impaction. RX2.

On physical exam, however, ulnarcarpal impaction test was not painful and there was no tenderness over the TFCC. There was a ganglion cyst at the radial side of the left wrist. Grip strength was right greater than left. The left shoulder had full motion with no weakness or tenderness in any plane. The bilateral elbow exam was normal. Dr. Howard diagnosed ganglion cyst at the left wrist and vaso-spastic disease. Dr. Howard could not causally connect the ganglion to Petitioner's job activities. He opined that had the vaso-*spastic* disorder resolved and, while most likely caused by smoking, it could be temporarily aggravated by repetitive gripping. He opined that Petitioner required no additional testing or treatment and could return to work full duty. RX2.

Petitioner testified he did know the reason that Dr. Workman, Dr. Golz, Dr. Austin and Dr. Howard failed to document left shoulder symptoms at the office visits, because from the start he reported to all the physicians he had pain and could not fully raise his left shoulder.

Petitioner's girlfriend, Donna Mochaby, testified that they lived together in March 2010. She observed Petitioner could not raise his left arm and he had pain after work.

On May 3, 2010, Petitioner cancelled an appointment with Dr. Workman because he could not make the co-pay. Petitioner returned to Dr. Workman on May 10, 2010, and reported left wrist pain with increased swelling "the other day on a tractor". He reported numbness to the

hand and fingers with left shoulder pain lifting his arm above his head. He attended the Emergency Room the previous Thursday (5/7/12) to get a work slip since Dr. Howard released him to return to work without restrictions. On exam, the left shoulder was painful with extension and internal rotation. There was swelling at the posterior lateral left wrist and pain with range of motion. Dr. Workman ordered x-rays of the left wrist and shoulder at Petitioner's request. He took Petitioner off work for one month. RX7.

On May 15, 2010, Petitioner underwent left wrist and left shoulder MRIs at Herrin Hospital. The radiologist opined the wrist films were of limited diagnostic quality, but interpreted swelling along the distal left ulna. The left shoulder MRI revealed mild AC joint arthritis, moderate rotator cuff tendinosis without a full thickness tear, and possible bursitis. PXA, Dep PX3.

Based upon that testing, Dr. Workman referred Petitioner to Dr. Angela Freehill, who saw Petitioner on June 8, 2010. Prior to the visit, Petitioner completed an intake form stating that he experienced left shoulder and wrist pain of 6/10 with numbness and tingling. Hobbies included fighting. PX1, Dep, PX2. On physical exam, Petitioner had a positive impingement and Hawkins sign at the left shoulder. X-rays showed a Type I acromion. Dr. Freehill did not have the MRI, but diagnosed left shoulder impingement syndrome. She recommended therapy, Naproxen and a referral to Dr. Joon Ahn for the left wrist. Work status was not addressed. PX4.

On June 9, 2010 Petitioner returned to Dr. Workman for left shoulder and wrist pain. He denied doing anything at home. He was instructed to follow up with Dr. Freehill. RX7.

Petitioner first saw Dr. Ahn on June 14, 2010. He related the left shoulder and wrist symptoms to pulling 85 pound metal parts off a conveyor belt. Plain film x-rays, according to Dr. Ahn, revealed a cystic lesion on the lunate area of the ulna area consistent with ulnar impaction syndrome. On exam, Petitioner had a positive ulnar impaction test. Dr. Ahn diagnosed ulnar impaction syndrome and degenerative TFCC tear. He opined that the symptoms might have been noticed after the trauma, but that this was a chronic problem. He injected the ulnar carpal junction with cortisone and provided Petitioner with a splint. Dr. Ahn opined that if conservative measures failed, Petitioner would require surgery. PXH.

Petitioner returned to Dr. Ahn on July 14, 2010, and reported slight improvement from the injection. Dr. Ahn advised Petitioner to stop using the splint and to follow up if the symptoms persisted. PXH.

On July 20, 2010, Petitioner returned to Dr. Freehill and reported he did not undergo the physical therapy previously recommended. Dr. Freehill reviewed the May 15, 2010, MRI and did not find any evidence of rotator cuff tearing. She injected the subacromial space with cortisone, recommended Petitioner start physical therapy two times a week for one month, and took him off work. PXA, Dep. PX4.

Petitioner underwent therapy at NovaCare in West Frankfort, Illinois. PXK.

Petitioner returned to Dr. Ahn on August 16, 2010, and reported the left wrist symptoms had improved, but he was concerned they would flare up if he returned to work. Dr. Ahn released Petitioner to full duty for the wrist condition and told him to follow up on an as needed basis. PXH.

Petitioner returned to Dr. Freehill August 24, 2010, and reported he had not had significant relief from the prior injection, therapy and medication. As such, Dr. Freehill recommended surgery. She kept Petitioner off work at that time. PXA, Dep. PX4.

Petitioner testified that his left shoulder symptoms continued to worsen after being taken off work March 19, 2010, and that the left wrist symptoms remained about the same.

On August 30, 2010, Dr. Freehill performed a left shoulder arthroscopy consisting of subacromial decompression with some debridement of the labrum and subscapularis tendon. She prescribed post-operative therapy and kept Petitioner off work. PXA, Dep. PX4.

On October 11, 2010, Petitioner returned to Dr. Ahn for the left wrist. He had still not returned to work, but his symptoms had worsened to the point that Dr. Ahn recommended surgery at that time. PXH.

On October 26, 2010, Dr. Ahn performed an arthroscopic repair of a TFCC tear, distal ulnar wafer resection and chondroplasty of the ulnar side of the lunate. PXO.

On November 3, 2010, Dr. Ahn prepared an addendum to his office note. He opined that Petitioner suffered a traumatic injury pulling a 20 to 80 pound metal belt off the conveyor that could contribute to further tear of the TFCC. He added repetitive twisting motion with the wrist could be a contributing factor. PXH.

On January 17, 2011, Petitioner returned to Dr. Freehill and reported he had no left shoulder difficulty and he could do everything he wanted to do. The exam showed flexion to 160 degrees. Dr. Freehill released him to return to work full duty and placed him at maximum medical improvement. PXA, Dep. PX4.

On January 24, 2011 Petitioner returned to Dr. Ahn and reported his left wrist was doing well without complaints. Dr. Ahn released him to regular duty and placed him at maximum medical improvement. PXH.

Petitioner testified that he still experiences pain and weakness in the left wrist. He does not ride his motorcycle and has difficulty picking things up. He was able to continue performing his job with some pain. He takes pain medication that he was already on for a chronic low back problem. He testified he is not currently working and has applied for Social Security disability.

On January 28, 2013, Dr. Rotman performed a records review at Respondent's request. Dr. Rotman opined that Petitioner's left wrist and left shoulder surgeries were not causally connected to his work activities. He explained that the left shoulder condition was not work related because the first documented left shoulder complaint was May 10, 2010, when Petitioner

was no longer working. He explained that the left wrist condition was not work related because the first documented *ulnar* sided wrist symptom was June 14, 2010, when Petitioner was no longer working. RX1.

On January 9, 2014, Dr. Rotman reviewed the job video admitted as Respondent's Exhibit 3. His opinion remained that, even if Petitioner had an onset of left shoulder symptoms and ulnar sided left wrist symptoms while working, the work activities did not cause or aggravate the conditions. RX1.

Dr. Rotman testified by way of deposition on January 27, 2014. He testified consistent with his reports. In preparation for the January 28, 2013, report, Dr. Rotman reviewed the records from Dr. Austin, Dr. Workman, Dr. Freehill and Dr. Ahn. He reviewed the actual MRI films of the left shoulder and left wrist, as well as the color intra-operative photos from the left shoulder surgery performed by Dr. Freehill and the left wrist surgery performed by Dr. Ahn. He testified that based upon his review of the medical records, the first time Petitioner actually received treatment or had symptoms for the conditions for which Dr. Ahn operated, was when he first saw Dr. Ahn June 14, 2010. RX1.

Dr. Rotman reviewed the left wrist x-ray from March 12 and March 19, 2010. He interpreted the March 12, 2010, x-ray to be normal and the March 19, 2010, x-ray to show a little cyst in the lunate, potentially related to Kienbock's disease. He interpreted the May 15, 2010, left wrist MRI to demonstrate edema in the distal ulna, a cyst in the lunate, and some fraying of the central portion of the TFCC. RX1.

Dr. Rotman testified that, based upon review of all the medical records, imaging studies, surgery photographs and job description, the surgery performed by Dr. Ahn was unrelated to Petitioner's work activities for Respondent. He explained that Dr. Ahn treated Petitioner for an area of left wrist pain that developed only *after* Petitioner had been off work, and that all the symptoms while Petitioner was working were on the *radial* or thumb side of the wrist. RX1.

Dr. Rotman further testified that the left shoulder surgery performed by Dr. Freehill was likewise unrelated to Petitioner's work activities for Respondent. He explained that the first documentation of left shoulder pain in the records was almost a month and a half after Petitioner stopped working on March 19, 2010. He further testified that the degenerative changes found at the time of surgery could become symptomatic irrespective of activity performed. RX1.

Dr. Rotman subsequently reviewed the job video. Based upon the job video, his opinion remained that there was no relationship between the left wrist and left shoulder surgeries and Petitioner's work activities for Respondent. With respect to the shoulder, Dr. Rotman explained that there was not significant shoulder level type work to explain a chronic impingement syndrome. With regard to the wrist, he explained that the job activities did not involve significant ulnar deviation of the wrist. Finally, Dr. Rotman explained that a "repetitive job" requires doing the same thing several cycles a minute with the wrist or shoulder going in the same direct for at least four or five hours a day. RX1.

On cross-examination, Dr. Rotman agreed that video clips 7 and 9 could have irritated ulnar impaction syndrome. The Arbitrator notes that Petitioner did not describe performing these activities in Link and Pack.

On re-direct examination, Dr. Rotman explained that if the work activities had contributed to the conditions and surgery performed by Dr. Ahn he would have expected the conditions to be documented as symptomatic by Dr. Golz on March 26, 2010, and by Dr. Howard on April 26, 2010. RX1.

Dr. Freehill testified by way of deposition on December 3, 2013. She testified consistent with her treating records. She testified that at the time of surgery she observed some fraying of the labrum, which was a normal degenerative kind of change for someone of Petitioner's age, and a large bone spur that was the cause of the impingement in the shoulder. She performed a subacromial decompression. When asked whether Petitioner sustained an injury to the shoulder in the course of his employment, Dr. Freehill testified that Petitioner reported having pain associated with his work activity and she had no reason to think otherwise. She stated, "It was a reasonable cause to think that someone lifting 85 pounds repetitively off a conveyor belt would have shoulder impingement. So I do think yes, it was related to his work activity. PXA.

On cross examination, Dr. Freehill agreed that there would be no causal relationship between the left shoulder condition that she treated and the work activities if Petitioner did not develop an onset of shoulder pain or a worsening of pain while performing the work activities. She admitted that she had not reviewed any outside medical records. She did not know whether Petitioner worked at chest level, above shoulder level, or below chest level. Dr. Freehill testified that when she examined Petitioner on January 14, 2011, there was no evidence of functional loss to the left shoulder. PXA.

On re-direct examination, Dr. Freehill testified that if, in fact, Petitioner had reported left shoulder pain to Dr. Workman on March 26, 2010, then the left shoulder condition could be work related. PXA.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, and issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

To obtain compensation under the Illinois Worker's Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of*

Greater Chicago v. Illinois Workers' Compensation Comm'n, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained accidental injuries on March 13, 2010, that arose out of and in the course of his employment with Respondent. In so concluding, the Arbitrator finds the opinions of Dr. Rotman and Dr. Howard more persuasive than the opinions of Dr. Freehill and Dr. Ahn. The Arbitrator notes that Petitioner testified credibly regarding his work activities and that he primarily used his left upper extremity working in Link and Pack from January through March 2010, pulling the 85 pound belts. However, the medical records do not support, and in fact contradict, Petitioner's testimony regarding the location of his left wrist pain while working and the onset of his left shoulder pain while working.

Left Wrist

Dr. Austin, surgeon Dr. Golz, and surgeon Dr. Howard, all examined Petitioner for left wrist pain between March 19 and April 26, 2010. Dr. Austin and Dr. Howard specifically examined the left wrist for ulnar compaction syndrome and a TFCC tear. Both exams were normal. Dr. Golz's note makes no suggestion of an ulnar compaction syndrome or a TFCC injury. While the condition was perhaps present by x-ray, it was not symptomatic and did not require treatment.

The first evidence of a symptomatic ulnar compaction syndrome or a TFCC tear was June 14, 2010, when Petitioner saw Dr. Ahn. This is almost three months after Petitioner stopped working for Respondent, on March 19, 2010.

Dr. Ahn did not testify in this case. Dr. Ahn's causation opinion, according to his records, was based upon a history that Petitioner suffered a traumatic injury to his left wrist. However, Petitioner did not allege or testify as to a specific traumatic accident.

Dr. Rotman reviewed all the imaging studies, medical records, and job video. He testified that video clip 11, the job Petitioner primarily performed, showed no significant ulnar deviation maneuvers that would aggravate an ulnar impaction syndrome.

While he was still working, Petitioner suffered from a ganglion cyst at the left wrist and a temporary flare-up of a vaso-spastic disorder. No physician opined that the cyst was work related. Dr. Howard opined that the vaso-spastic disorder was most likely secondary to Petitioner's two-pack a day smoking history. He further opined that, although work activities could temporarily aggravate the disorder, it appeared that the temporary aggravation had resolved when he examined Petitioner.

For these reasons, the Arbitrator finds that Petitioner failed to prove that the left ulnar compaction syndrome and TFCC tear were causally related to his work activities for Respondent.

Left Shoulder

Petitioner was shown the Injury Report that was completed on March 18, 2010, and agreed that it did not include any reference to an injury to the left shoulder. The Arbitrator notes that the Injury Report, marked as Respondent's Exhibit 9, was not listed on Respondent's Exhibit List (Arbitrator's Exhibit 4), nor was it offered into evidence. However, Petitioner did testify as to its contents and his testimony is so noted.

Petitioner saw Dr. Workman on March 12 and Dr. Golz on March 26, 2010. Neither treatment record documents any left shoulder complaints or injury. While Dr. Workman documented left "upper arm" pain on March 26, there was no physical examination of the left *shoulder*. To conclude that Dr. Workman was documenting shoulder pain in this note would be speculative, particularly when his office note of May 10, 2010, specifically documented *shoulder* pain and a left shoulder examination was conducted. Further, Dr. Howard documented a ***normal*** shoulder exam on April 26, 2010.

Dr. Rotman, unlike Dr. Freehill, had all of the aforementioned medical records available and reviewed same when addressing causation. Both doctors opined that the left shoulder symptoms from impingement could become symptomatic and require treatment irrespective of Petitioner's activity.

For these reasons, the Arbitrator finds that Petitioner failed to prove that the left shoulder impingement syndrome and need for surgery were causally related to his work activities for Respondent.

All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM SCOTT GREGORY,

Petitioner,

vs.

NO: 14 WC 33179

RHL INSULATION & FIRE STOP,

18IWCC0434

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms the finding that the aggravation and acceleration of Petitioner's right and left knee osteoarthritis are causally related to his work injury. We also affirm the award of prospective right total knee arthroplasty. However, we find that the award for the left knee total arthroplasty is premature and speculative. Although Dr. Sclamberg opined that a left knee arthroplasty is "probable," we find there are questions that remain regarding whether Petitioner's left knee osteoarthritis was temporarily or permanently aggravated. Dr. Sclamberg testified, "I would certainly start with the more symptomatic knee, and then we have to kind of wait and see how – sometimes if you take the stress off of one, it helps the other, but likely he's – he needs both of his knees done." *Px3 at 26-27.* On cross-examination, Dr. Sclamberg agreed that if Petitioner lost weight, he could likely extend the time for the need for a knee replacement as there would be less stress on the knee. *Id. at 45.* Based on Dr. Sclamberg's opinion that he would "wait and see"

combined with the potential impact of Petitioner's weight-loss, we find that the question about the reasonableness and necessity of a left knee arthroplasty should be reserved until a later date if Dr. Sclamberg prescribes it.

We also modify the Arbitrator's award of a weight-loss program. Respondent's Section 12 examiner, Dr. Mash, recommended Petitioner see a weight-loss specialist prior to undergoing surgery. However, although Dr. Sclamberg testified that had discussed weight loss with Petitioner and wanted him to lose weight, it does not appear that he actually prescribed a formal weight-loss program as a prerequisite to the right total knee arthroplasty. Accordingly, we award follow-up visits with Dr. Sclamberg to determine the medical necessity of a formal weight-loss program prior to the prescribed surgery. We are mindful that Petitioner's success with any weight-loss program is highly dependent upon his compliance and motivation. Since the goal is for Petitioner to reach maximum medical improvement as soon as safely possible, we vacate the Arbitrator's award to the extent that it could be interpreted as requiring a formal weight-loss program prior to surgery.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,033.60 per week for a period of 111-1/7 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 the sum of $52,147.34 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the prospective total right knee replacement as prescribed by Dr. Sclamberg along with appropriate follow up visits, and a determination by Dr. Sclamberg regarding whether a formal weight-loss program is medically necessary prior to surgery, 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 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.

18IWCC0434

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: JUL 16 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 5/23/18
49

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

GREGORY, WILLIAM SCOTT
Employee/Petitioner

Case# **14WC033179**

RHL INSULATION & FIRE STOP
Employer/Respondent

18IWCC0434

On 11/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK ET AL
JOHN M POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

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

W. Gregory v. RHL Insulation, Etc., 14 WC 033179

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)

William Scott Gregory
Employee/Petitioner

v.

RHL Insulation & Fire Stop
Employer/Respondent

Case # 14 WC 033179

18IWCC0434

An *Application for Adjustment 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 **9/7/16**. 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, **7/21/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$80,620.80**; the average weekly wage was **$1,550.40**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$59,787.70** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$59,787.70.**

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 $1,033.60/week for 111 1/7 weeks, commencing 7/22/14 through 9/7/16**, as provided in **Section 8(b) of the Act.**

Respondent shall pay **reasonable and necessary medical services of $52,147.34**, as provided in **Sections 8(a) and 8.2 of the Act.**

Respondent shall authorize and pay for a weight loss program under Dr. Sclamberg's direction, right total knee replacement surgery and left total knee replacement surgery, as recommended by Dr. Sclamberg in his deposition, along with all related expenses.

Petitioner's claim for Penalties and Attorney's Fees is denied.

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

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

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

Signature of Arbitrator

November 28, 2016
Date

ICArbDec19(b)

NOV 28 2016

FINDINGS OF FACT

Petitioner was employed by Respondent as an insulator. He had worked for Respondent for about 3 weeks prior to the accident. Petitioner had been a union insulator, working out of Local 17 of the Heat and Frost Insulators for 3 years. His work consisted of insulating plumbing, duct work and roof heads, which required him to work on ladders approximately 90% of his time. He needed to get up and down ladders to get materials, and the majority of his work was done at chest level or above. He worked on his feet about 8 hours a day.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on July 21, 2014. He was working at the Goldblatts building on 47th and Ashland and was carrying a box of fittings and tripped over a tool belt left behind on the floor, falling onto his right knee. He immediately noted pain in his right knee, and was taken by ambulance to Mercy Hospital.

Prior to this incident, he injured his right knee in April of 2013, when he fell on his right knee and right upper extremity. He was seen for treatment at Physician's Immediate Care and released with a knee sleeve. (PX#8) Between April 2013 and July 21, 2014 he was able to perform all aspects of his job as an insulator with respect to his right knee, did not miss time from work due to his right knee and did not receive any medical care for his right knee. It is noted that Dr. Wolin , who provided a records review dated August 14, 2007 regarding an injury to Petitioner's left knee in 2006, noted that Petitioner complained of right knee pain from kneeling at work on June 27, 2005. (PX#7) The 2005 knee complaints and treatment are not otherwise in evidence. At the time of injury, Petitioner was 5' 10" tall and weighed 320 pounds, according to his PCP's records. (PX#2) Petitioner testified that he weighed less than 300 pounds at the time of the accident. His weight was estimated at 319+ pounds at Mercy.

At Mercy Hospital, Petitioner was examined, underwent x-rays and was prescribed a knee immobilizer and crutches. He was also prescribed pain medications, authorized off work, and told to follow up with his primary care physician. (PX#1)

Petitioner saw his primary care doctor, Dr. Richard Hayes, on July 22, 2014. Dr. Hayes suspected a meniscal tear and ordered an MRI of the right knee. The MRI took place at Edgebrook Radiology on July 22, 2014. It revealed medial and lateral meniscal tears, an ACL partial tear, a Baker's cyst and medial compartment osteoarthritis. (PX#2)

Petitioner was next seen by Dr. Steven Sclamberg, an orthopedic surgeon, on July 29, 2014. Dr. Sclamberg previously performed a left knee arthroscopy on Petitioner in August of 2006. Following that surgery, Petitioner was released to full duty work by January of 2007. Petitioner testified that he did not receive any treatment for his left knee since 2008 and was able to perform all aspects of job as an insulator relative to his left knee from 2008 through July 21, 2014. Following the 2006 injury to his left knee, Petitioner was seen by Dr. Preston Wolin on October 3, 2007 for an independent medical evaluation. Dr. Wolin felt Petitioner was capable of full duty work and did not believe the pre-existing osteoarthritic changes in his left knee were the type that would predict a necessity for future knee replacement. (PX#7)

Dr. Sclamberg examined Petitioner on July 29, 2014, reviewed the MRI, injected his right knee and prescribed physical therapy and anti-inflammatory medications. Petitioner underwent physical therapy at ATI from August 1, 2014 through October 3, 2014. (PX#5) Petitioner testified that his right knee was not getting better with therapy. On October 9, 2014, Dr. Sclamberg recommended surgery for Petitioner's right knee. (PX#3)

On October 21, 2014, Petitioner was seen for a §12 examination by Dr. Steven Mash, at the request of Respondent. Dr. Mash found that Petitioner was in need of right knee surgery and felt that the need for the surgery was causally related to his work accident. (RX#1)

Petitioner underwent surgery at Accredited Ambulatory Care on October 31, 2014. The surgery consisted of partial medial and lateral meniscectomies, synovectomy and debridement of patellar femoral chondromalacia. (PX#4)

Petitioner followed up with Dr. Sclamberg on November 20, 2014. Dr. Sclamberg recommended therapy and a TENS unit. Petitioner testified that in the past he had used a TENS unit for his left knee, and received relief from it. Petitioner began physical therapy at ATI on December 1, 2014 and continued through June 19, 2015. (PX#3, PX#5)

On December 30, 2014, Petitioner was seen again by Dr. Sclamberg. Dr. Sclamberg's notes indicate that Petitioner's therapist hyperflexed his right knee and he developed pain with swelling and giving away. He further noted that Petitioner was feeling better than pre-op prior to this. Petitioner testified that he had just gotten on a treadmill and was trying to get accustomed to the speed when his knee bent backward and out to the right. He had immediate pain and had to get off the treadmill. His therapist applied ice and a TENS unit. The event is not well documented in the ATI records, but it does seem to have occurred around December 22, 2014. (PX#5) On December 30, 2014, Dr. Sclamberg

injected Petitioner's right knee, recommended that he continue therapy and recommended that he remain off work. Petitioner was again seen by Dr. Sclamberg on January 27, 2015 and, at that time, Dr. Sclamberg's impression changed to bilateral knee pain. Petitioner testified that he began favoring his right knee by putting more weight on his left leg, and began to develop pain in his left knee. Dr. Sclamberg recommended that Petitioner continue therapy, remain off work and use a TENS unit. (PX#3) Petitioner testified that the TENS unit was never authorized, so he ended up purchasing a TENS unit himself.

On March 23, 2015, Petitioner was seen again by Dr. Sclamberg. His notes reflect Petitioner was at therapy on a treadmill when he developed pain along the medial aspect of the right knee. Dr. Sclamberg injected Petitioner's right knee, recommended that he continue therapy and recommended that he undergo a total right knee arthroplasty. Petitioner continued to complain of pain in both knees when seen by Dr. Sclamberg on April 20, 2015. Dr. Sclamberg continued to recommend therapy and off work pending an upcoming IME. (PX#3)

On May 15, 2015, Petitioner was again seen by Dr. Mash at the request of Respondent. Petitioner testified that Dr. Mash did not examine him at that time and did not discuss with him the incident on the treadmill at physical therapy. Dr. Mash's report indicates that he did perform a physical exam on Petitioner's right knee. (RX#1)

Petitioner continued to follow up with Dr. Sclamberg on June 1, 2015, July 6, 2015 and August 18, 2015. At each of these appointments, Petitioner complained of bilateral knee pain, right worse then left, and Dr. Sclamberg recommended weight loss and right knee replacement surgery. (PX#3)

Petitioner testified that his temporary total disability benefits were terminated on August 16, 2015. (RX#4) Petitioner saw Dr. Sclamberg on October 15, 2015, January 15, 2016 and March 11, 2016. He continued to complain of knee pain, worse on the right then the left, and Dr. Sclamberg continued to recommend that Petitioner undergo arthroplasty surgery and remain off work. (PX#3)

Petitioner testified that he desired to have the Arbitrator order Respondent to authorize and pay for right and left total knee replacement surgeries, and a weight loss program prior to those surgeries. Petitioner identified claimed medical bills in Petitioner's Exhibit #6 totaling $52,147.34, and testified they remained outstanding at the time of arbitration.

Petitioner continues to experience pain in his right knee with a giving out sensation on stairs and with walking. He uses his TENS unit to control pain. He continues to experience pain in his left knee.

On cross examination, Petitioner agreed that he initially injured his right knee, not his left knee. Following his right knee surgery by Dr. Sclamberg, the pain never resolved, but he was feeling better after surgery and before the treadmill incident. He felt that he was on the road to recovery. Following the treadmill incident, Dr. Sclamberg took x-rays and told Petitioner his knee was beyond repair and needed to be replaced. Petitioner testified that he continued with therapy after the treadmill incident and made progress in therapy. Petitioner estimates that his current weight is 320 pounds. He has tried to lose weight, but has not been successful. Dr. Sclamberg recommended that Petitioner loose weight.

On re-direct examination, Petitioner testified that prior to this accident on July 21, 2014 he was able to do 100% of his job as a union insulator. He also testified that he told Dr. Sclamberg on January 27, 2015 that he was having pain in his left knee as well as his right knee. Petitioner also testified that following the October 31, 2014 surgery, he thought he was getting better, was on the road to recovery and thought he would be able to go back to his regular work.

On April 11, 2016, Dr. Sclamberg gave his evidence deposition. Sclamberg is a board certified orthopedic surgeon. He testified that Petitioner had an acute injury consisting of the medial and lateral meniscal tears, which were causally related to the accident. (PX#3 p.11-12) He also testified that Petitioner had pre-existing osteoarthritis which was aggravated and/or accelerated by the accident. (Id. at 11) Dr. Sclamberg did not believe, based on what he saw during the October 31, 2014 surgery, that the osteoarthritis in Petitioner's knee warranted knee replacement surgery at that time. (Id. at 16-17) The fact that Petitioner was not having any problems prior to the accident further indicates that Petitioner did not need total knee replacement at the time of the surgery. (Id. at 17-18) Dr. Sclamberg prescribed the TENS unit for Petitioner to help diminish pain, and testified that the TENS unit was reasonable and necessary to cure or relieve Petitioner of the effects of his condition. (Id. at 18) Petitioner's weight obviously has contributed to the osteoarthritis.

Dr. Sclamberg also testified that the initial surgery went well and Petitioner was responding well to therapy when his knee was hyperflexed in therapy. (Id. at 19) Dr. Sclamberg found swelling and tenderness in the knee on December 30, 2014 and gave Petitioner an injection in response to the hyperflexing of the knee, due to the inflammation that was

caused. (Id. at 19-20) When Dr. Sclamberg saw Petitioner on January 27, 2015, Petitioner was limping and was complaining of bilateral knee pain. (Id. at 20) Petitioner was favoring the right knee and putting stress on the left knee causing bilateral symptoms. (Id. at 21) By March 23, 2015, Dr. Sclamberg was of the opinion that Petitioner's right knee condition warranted a discussion of right knee replacement surgery. On April 20, 2015, Dr. Sclamberg noted that Petitioner continued to have a limping gait and crepitation in his right knee. Concerning the left knee, Dr. Sclamberg testified that the condition of the left knee was caused in whole or in part by the favoring of the right knee and limping, and further testified that the gait alteration accelerated the need for treatment and probable arthroplasty of the left knee. (Id. at 27)

Dr. Sclamberg reviewed Dr. Mash's IME report and discussed it with Petitioner. Petitioner told Dr. Sclamberg that Dr. Mash never actually touched him during the visit. (Id. at 29-30) Dr. Sclamberg testified that Dr. Mash's report did not change his opinion that Petitioner's fall at work exacerbated and aggravated the underlying arthritis making it symptomatic and requiring bilateral knee replacement surgeries. (Id. at 30) Dr. Sclamberg recommended Petitioner remain off work pending the right knee arthroplasty. (Id. at 32) Dr. Sclamberg's current diagnosis of Petitioner is bilateral end stage knee osteoarthritis and he testified that condition is causally related to the July 21, 2014 accident and its sequelae. (Id. at 36)

On cross examination, Dr. Sclamberg testified that Petitioner did not need total right knee replacement surgery at the time of the October 31, 2014 surgery. (Id. at 40, 43) In explaining why Petitioner needed the knee replacement surgery only five months later, he testified that Petitioner had underlying asymptomatic osteoarthritis, was doing well after arthroscopy, and had a intervening occurrence in therapy, following which he wasn't doing well, and he had no other surgical option than knee replacement for treatment (Id. at 43-44) Dr. Sclamberg did agree that if Petitioner lost weight, it may extend the time for the need for knee replacement surgery. (Id. at 44)

Dr. Mash testified via evidence deposition, at the request of Respondent, on June 2, 2016. The first examination took place on October 21, 2014, before Petitioner's surgery. Dr. Mash diagnosed a tear of the medial and lateral menisci superimposed upon osteoarthritis of the right knee. (RX#1, p.12) He testified that the meniscal pathology related to the July 21, 2014 accident and that the treatment Petitioner received was reasonable and necessary as of October 21, 2014. (Id. at 12-13) He further opined that the medications Petitioner was taking were reasonable and necessary but did not

think a TENS unit would help. (Id. at 14-15) Dr. Mash reviewed the records from Petitioner's April 2013 right knee contusion and testified that it appeared Petitioner had recovered from that injury. (Id. at 11)

Dr. Mash testified that he saw Petitioner a second time on May 5, 2015. He noted that Petitioner was unable to do normal activity, had difficulty with stairs and was unable to squat, stoop, kneel or climb, and noted that the exam was unchanged, except for healed surgical scars. (Id. at 17) His diagnosis at this time was status post arthroscopic medial and lateral meniscectomy superimposed upon pre-existing osteoarthritis. (Id. at 20) He testified that Petitioner suffered significant osteoarthritis of the right knee, and needed permanent restrictions and knee replacement surgery, but did not feel that the need for the surgery was related to the injury on the job. (Id. at 21-22) He felt that Petitioner's medications were appropriate, with the exception of analgesic compound cream, and did not believe the TENS unit would provide any improvement. (Id. at 22)

On cross examination, he testified that Petitioner was at MMI as of July 24, 2015 (Id. at 23) He did not review any medical records from physical therapy and was not aware of the injury that occurred in therapy. (Id.) He testified that the treatment Petitioner received was excessive and unreasonable both pre-operatively and post-operatively. (Id.at 34-35) He then testified that there was quite a bit of literature that supports conservative treatment of meniscal tears with injections, physical therapy and medications. (Id. at 38) He also testified that it was not appropriate for Dr. Sclamberg to order the MRI the day after the injury. (Id.) The Arbitrator notes that Dr. Hayes ordered the MRI, not Dr. Sclamberg. Dr. Mash did agree that Petitioner needed post-operative physical therapy and testified that he could not provide any opinions concerning the injury that occurred in physical therapy to Petitioner. (Id. at 39–40) He testified that Petitioner had no grinding in his knee on the first exam to a reasonable degree of medical certainty, but he did find grinding on the second exam. (Id. at 41) When asked if that represented a progression in Petitioner's condition, he testified that there probably was grinding on the first exam, but he failed to note it. (Id. at 42) He did not review any films in conjunction with his second evaluation despite writing in his second report that imaging studies and the intraoperative films were necessary to provide opinions concerning Petitioner's condition and the need for treatment. (Id. at 44) He noted that Petitioner lost 20 pounds between the two visits, but did not believe that physical therapy was appropriate for weight loss. (Id. at 44–46) He recommends Petitioner see a weight loss specialist or a bariatric specialist for weight loss prior to

having the total knee replacement surgery. (Id. at 47) He does recommends use of a TENS unit to his own patients for chronic musculoskeletal pain, but not if it involves the extremities. (Id.)

Respondent submitted retrospective UR reports as Exhibits 2 and 3. There was no evidence of Dr. Sclamberg's response, other than his deposition testimony.

Exhibit 2 contained denials for topical analgesic compounds dated 11/17/2014 and 12/1/2014. The compound medications were considered not medically necessary, pursuant to ODG Guidelines. Medical necessity has not been established for these compounds. NSAIDs are recommended. (Rx#2)

Exhibit 3 contained denials for the TENS unit and a partial certification for therapy in December of 2014 and for 2 visits after 3/23/15.

CONCLUSION OF LAW

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

F. Is Petitioner's current condition of ill-being causally related to the injury?
K. Is Petitioner's entitled to any prospective medical care?

The Arbitrator finds that the Petitioner's current condition of ill-being with respect to his bilateral knees is causally related to his July 21, 2014 accident (bilateral end-stage knee osteoarthritis, right knee status post arthroscopic surgery of 10/31/2014, complicated by aggravation in therapy in December of 2014, refractory to conservative care post surgery, left knee osteoarthritis aggravated by limping and favoring the symptomatic right knee). The Arbitrator further awards Petitioner prospective medical care consisting of a weight loss program under the direction and referral of Dr. Sclamberg and right total knee replacement surgery. Following Petitioner's convalescent from right knee surgery, the Arbitrator further awards left total knee replacement surgery, if offered by Dr. Sclamberg.

Both Dr. Sclamberg and Dr. Mash agree that Petitioner suffers from significant osteoarthritis of his right knee and is in need of right total knee replacement surgery. Petitioner testified that after surgery he felt he was on the road to recovery in therapy and anticipated being able to return to work. He then hyperflexed his knee on a treadmill during therapy in December 2014, and his condition rapidly deteriorated. On December 30, 2014, Dr. Sclamberg injected the right knee due to the inflammation caused by the hyperflexion injury. (PX#3, p. 19-20) On January 27, 2015, Petitioner complained of bilateral knee pain to Dr. Sclamberg. Petitioner testified that he began favoring his right knee by bearing

more weight on his left leg and developed pain in the left knee. Dr. Sclamberg testified that the Petitioner was limping at the January 27, 2015 appointment to favor the right knee, and was putting stress on the left knee. Dr. Sclamberg testified that the gait alteration accelerated need for treatment and arthroplasty in both knees. He further testified that Petitioner had two components to his knee injury. The first was an acute injury consisting of the lateral and medial meniscal tears. The second was an aggravation of the pre-existing osteoarthritis. Both Dr. Sclamberg and Dr. Mash agreed that Petitioner was asymptomatic prior to the accident relative to his right knee. Dr. Sclamberg further testified that based on what he saw in Petitioner's right knee during surgery on October 31, 2014, the osteoarthritis that was present at that time did not warrant knee replacement surgery. Dr. Sclamberg testified that the fall at work exacerbated and aggravated the underlying arthritis making it symptomatic and requiring two knee replacement surgeries. (Id. at pg. 30)

On cross examination, Dr. Sclamberg explained the chain of events which led to his conclusion that the need for the knee replacement surgeries related to the July 21, 2014 accident. He testified that Petitioner had an underlying asymptomatic osteoarthritis prior to the accident, was doing well after the October 31, 2014 arthroscopy, had an intervening event occur in therapy after which he was not doing well, and he saw no surgical option other than knee replacement. (Id. at 44)

Dr. Mash concurred that Petitioner required right knee replacement surgery due to the osteoarthritis, but did not provide an opinion on whether the underlying osteoarthritis was aggravated and/or accelerated by the accident. He did say Petitioner could not squat, stoop, kneel or climb on May 5, 2015, which was unchanged from October 21, 2014. Furthermore, he testified he did not have therapy records and was unaware that Petitioner injured his knee in therapy. As a result, he testified that he did not know anything about that injury and would not be able to provide any opinions about it. (RX#1, p. 40)

It is clear to the Arbitrator that but for the hyperflexing incident on the treadmill at therapy, Petitioner was making a good recovery and did not need knee replacement surgery at that time. Based on Dr. Sclamberg's opinion that the treadmill incident directly led to the need for the total knee replacement surgeries bilaterally, and Dr. Mash's testimony that he was unaware of the incident and could not provide any opinions about it, the Arbitrator finds Dr. Sclamberg's opinions credible and persuasive and finds that Petitioner's current condition of ill-being with respect to his bilateral knees and his need for bilateral knee replacement surgery is causally related to the accident. In so finding, the

Arbitrator finds that the Petitioner' testimony was credible. His testimony that he had no treatment regarding the left knee after recovering from the 2006 surgery and had only slight right knee treatment after the 2013 contusion is unrebutted and not contradicted by any medical records submitted into evidence. Furthermore, Dr. Mash opined that Petitioner's subjective complaints of pain were supported by the objective medical findings at both examinations, and he found no evidence of symptom magnification. Finally, Dr. Mash did not view the intraoperative films, so his no causation opinion is lacking in support. Dr. Sclamberg's causation opinion is supported by his testimony regarding the condition of Petitioner's right knee in surgery and is more persuasive in this case. The injury of July 21, 2014 and its sequelae aggravated and accelerated the pre-existing osteoarthritis conditions in Petitioner's knees, such that he is in need of the proposed arthroplasty procedures. See: Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193 (2003)

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

Petitioner claimed the following medical bills as outstanding at arbitration (Px#6):

1. Chicago Pain & Orthopedic Institute	$ 9,110.22
2. Accredited Ambulatory Care	$19,328.45
3. ATI	$13,966.91
4. Ashland Health	$ 4,880.40
5. RX Development	$ 4,321.36
6. Orthopedics & Rheumatology	$ 540.00
Total:	**$52,147.34**

All awarded bills herein are pursuant to §§8 (a) and 8.2 of the Act. Respondent is entitled to a credit for all bills paid.

Based on the Arbitrator's findings with respect to causation, the Arbitrator awards the medical bills from Chicago Pain and & Orthopedic Institute in the amount of $9,110.22, Accredited Ambulatory Care in the amount of $19,328.45, and Orthopedics & Rheumatology in the amount of $540.00. The awarded bills are subject to §§8.2 and 8(a) of the Act. If Respondent can show that the submitted bills contain improperly unbundled charges, the payment of the proper §8.2 charge discharges its liability and that of Petitioner.

Respondent objected to the bills from Ashland Health and RX Development and ATI on the basis of its utilization review reports and the opinion of Dr. Mash. The Arbitrator does not find the opinion of Dr. Mash persuasive on this issue. In his first report, and at his deposition, he testified that Petitioner's treatment through October 21, 2014

was reasonable and necessary. In his second report, he indicated that no cover letter or outside report was provided and that updated x-rays would be necessary to provide an opinion regarding Petitioner's current condition and need for further treatment. Dr. Mash testified that he was not provided imaging studies subsequent to that report. (RX#1, p.44) After being provided with medical records, Dr. Mash issued a report dated July 24, 2015, and testified concerning that report. He testified that it was unusual for Dr. Sclamberg to order an MRI the day after the accident, especially in somebody with underlying osteoarthritic change (Id. at 22) On cross examination, he changed his mind and stated that it was not inappropriate to order the MRI based on Petitioner's history of a twisting injury to the knee. (Id. at 38) Of course, Dr. Hayes ordered the MRI. Dr. Mash testified that Petitioner received numerous medications which were not customary in the medical marketplace (Id.at 22) but did not specifically indicate which medications were not customarily or typically provided. Dr. Mash also testified that he felt physical therapy was prolonged both pre-operatively and post-operatively, but did not give a cut-off date for therapy. He also testified he had no opinions following Petitioner's treadmill incident in therapy in December 2014 because he was unaware of it. He also appeared to contradict himself later in his testimony when he indicated that Petitioner may not have needed surgery for the meniscal tears, stating that there was quite a bit of literature supporting conservative treatment with injections, physical therapy and medications. (Id. at 38) The same conservative care that Dr. Mash says finds support in the literature he condemns as excessive and unreasonable, and he previously had testified that the surgery was reasonable and necessary. Based on the numerous inconsistencies by Dr. Mash's testimony on this issue, the Arbitrator accords Dr. Mash's testimony little weight on this issue.

Respondent introduced three utilization review reports into evidence. The first was done by Prium on November 17, 2014. (Rx#2) The report concluded that Terocin Dis 4-4% and Lidopro ointment were not medically necessary. Both of these medications appear in the RX Development bill. The utilization review report states that "the necessary information to determine if the patient has not responded to other treatments …is also not available." (PX#2, pg.4) The Arbitrator notes that of all the records reviewed, the only progress note reviewed from Dr. Sclamberg is his August 11, 2014 note. All of the other records reviewed were either physical therapy notes or health insurance claim forms. The cover page of the denial letter indicates that this was a retrospective review. Section 8.7 (e) (2) mandates that when making retrospective reviews, the review "shall be based solely on the medical information available to the attending

physician or ordering provider at the time the health care services were provided." Based on the fact the utilization review decision was made based solely on Dr. Sclamberg August 11, 2014 progress note, and not the reminder of his office notes, the Arbitrator declines to accord any weight to the November 17, 2014 Prium utilization review report.

The second utilization review (part of Rx#2) was also done retrospectively by Prium, on December 1, 2014. (Rx#2) This report is based only on the operative report of Dr. Sclamberg, and not any of his office notes. Since Dr. Sclamberg was the attending physician ordering the medications, the Arbitrator finds the failure of the review examiner to consider the chart notes fatal to his opinion. The Arbitrator accords no weight to the December 1, 2014 utilization review report for also failing to comply with Section 8.7(e) (2) of the Act. As the medications covered in the Ashland Health and RX Development bills were disputed based on the above utilization review reports, and considering the Arbitrator's finding that Petitioner's condition of ill-being is causally related to his accident, the Arbitrator awards the Ashland Health bill in the amount of $4,880.40 and the RX Development bill in the amount of $4,321.36.

Respondent also offered a utilization review report from Triune Health Group dated April 3, 2015. (Rx#3) This report non-certified the use of a TENS unit and all therapy after December 30, 2014, as well as all passive/non-active modalities completed from December 2, 2014 through December 30, 2014. The report indicates that the reviewed medical records did not support medical necessity for the procedure/therapy requested, however, it does not indicate which, if any, medical records were reviewed in connection with his opinion. Furthermore, there is no indication that the healthcare professional providing the opinion was aware of the treadmill incident in physical therapy. Dr. Sclamberg's reports from December 30, 2014 and March 23, 2015 both document a hyperflexing injury in therapy. The Arbitrator finds no reference to that injury in the Triune utilization review report, and therefore the Arbitrator accords no weight to the Triune utilization review report dated April 3, 2015. As a result, the Arbitrator awards the physical therapy bill from ATI in the amount of $13,966.91. Concerning the use of the TENS unit, the report concludes that there is no information of the patient's trial use of a TENS unit, during physical therapy or in a clinical setting with noted improvements in function and symptoms. (RX#3, p.2) The Arbitrator finds no documentation in the report of which records were reviewed in reaching this conclusion. Petitioner testified his therapist applied a TENS unit after the treadmill injury. Petitioner testified he received a benefit from the use of the TENS unit to control his symptoms, as he did in the past, and the Arbitrator finds Petitioner credible in this regard. The Arbitrator further notes that Dr. Mash recommends the use of

a TENS unit for chronic musculoskeletal pain, and did not support the use of a TENS unit for joint pain. Dr. Sclamberg supported the use of the TENS unit. The Arbitrator finds the use of a TENS unit reasonable and necessary as prescribed by Dr. Sclamberg.

L. What temporary benefits are in dispute? TTD

Petitioner alleges he was temporally totally disabled for 111-1/7 weeks, from July 22, 2014 through the trail date of September 7, 2016. Respondent disputes this allegation, and claims Petitioner was temporally totally disabled from July 22, 2014 through August 16, 2015. The Parties agreed subsequent to the hearing that Respondent is entitled to a credit of $59,787.70 for TTD paid.

The Arbitrator finds that Petitioner was temporally and totally disabled from work for 111-1/7 weeks, from July 22, 2014 through September 7, 2016, based upon the Arbitrator's findings above regarding causation and prospective medical care and the fact that Petitioner is medically authorized off work by Dr. Sclamberg and is not yet at MMI. See: Interstate Scaffolding, Inc. v. The Illinois Workers' Compensation Commission, 236 Ill.2d 132 (2010)

M. Should penalties and fees be imposed upon Respondent?

The Arbitrator denies Petitioner's request for penalties and fees. This was a complicated case and Respondent's disputes on causation were not unreasonable, vexatious or in bad faith. Petitioner's claim for Penalties and Fees (Px#9) requests penalties and fees for non-payment of TTD benefits. Respondent's dispute regarding TTD in this case is in good faith.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VINCENTE C. MCELROY,

Petitioner,

vs. NO: 12 WC 01267

ALTON MENTAL HEALTH,

18IWCC0435

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms the Arbitrator regarding accident, causation, and vocational rehabilitation. However, the Commission finds that Petitioner failed to meet his burden of proof regarding maintenance benefits, so vacates the award of maintenance benefits between September 30, 2016, and November 15, 2016.

Petitioner injured his back while attempting to prevent a patient from falling on December 14, 2011. Petitioner's current condition of ill-being is causally related to his work accident. Petitioner was credible in his testimony, the medical records were consistent, and Respondent's independent medical exam physician, Dr. Williams, agreed that Petitioner had chronic low back and lower limb pain status post surgically successful instrumented L5/S1 fusion without current evidence of lumbosacral radiculopathy. (Rx3) Dr. Williams ultimately testified that he was not rendering opinions whether, in fact, Petitioner can physically perform

18IWCC0435

the job of an STA-I safely. (Rx5 p. 56)

The evidence supports that due to Petitioner's work-related injury and subsequent treatment, Petitioner continues to have limitations. Petitioner testified that he returned to work after the state cut off his benefits because he had no money coming in. (T. 27) He further testified that he was unable to fully perform his job due to his pain. (T. 34-35) Petitioner has worked in the same position for almost 20 years. The highest level of education Petitioner received was a high school diploma with potentially some training in the military. As Petitioner is unable to return to his current position and there is not an ability to accommodate Petitioner's restrictions, the Commission affirms the award of prospective vocational rehabilitation. However, Petitioner did not introduce any evidence of a self-directed job search or efforts in a vocational program to support his claim for maintenance, so the award of maintenance benefits for the period of September 30, 2016 through November 15, 2016, is vacated.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the award for maintenance is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall initiate vocational rehabilitation under §8(a) of the Act.

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

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

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

The party commencing 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: JUL 16 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 060518
49

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

McELROY, VINCENTE C
Employee/Petitioner

Case# **12WC001267**

ALTON MENTAL HEALTH
Employer/Respondent

18IWCC0435

On 1/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

JAN 19 2017

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

18IWCC0435

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Vincente C. McElroy
Employee/Petitioner

v.

Alton Mental Health
Employer/Respondent

Case # 12 WC 1267

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **November 15, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Vincente C. McElroy
Employee/Petitioner

Case # 12 WC 1267

v.

Consolidated cases: N/A

Alton Mental Health
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on December 14, 2011, he was employed as a Security Therapy Aide 1 by Respondent. He testified that he worked for Respondent for almost 25 years, and that of the 25 years he worked there, he held the position of Security Therapy Aide 1 ("STA-1") for about 19 years. He testified that Respondent's facility is a forensic psychiatric hospital, and that the clients have been deemed unfit to stand trial due to reasons of insanity. He testified that the patients were mentally ill criminals, and that some were charged with crimes such as murder. He testified that the patients were housed in rooms but no locked doors and that the patients had freedom of movement. He testified that the patients were housed in 3 different buildings called "pods" A, B and C, and that he typically worked C1 which housed 22 mentally retarded patients. He testified that he also worked in C2, which held 22 highly advanced clients. He testified that he was also tasked to respond to situations in other pods as well.

Petitioner testified that Petitioner's Exhibit 1 contained job descriptions which were very general. He testified that he received instruction on how to restrain patients, and that in the course of working, he has had to respond to a patient situation where he had to restrain the patient and that he was involved in usually 2-3 restraints per week. He testified that the Security Therapy Aide 1 position required him to be able to lift more than 25-30 pounds. He testified that when they did showers, they would have to pick up dirty linen. He testified that if they had to push a solid steel tray through the door, he would have to open the heavy door. He testified that they had to do unit searches for contraband at least once a week, which would require that he raise mattresses, flip chairs and get on the floor. He testified that the Security Therapy Aide 1 position required frequent bending and stooping, and that when he was working he was either standing or sitting, looking over the area.

Petitioner testified that while working on December 14, 2011, he injured his low back. He testified that he was assisting a client at the time of the accident, and that the client fell, grabbed Petitioner and "snapped" him down. He testified that he started to bring the client up, and that pain shot through him and he let the client go. He testified that the client weighed probably 300 pounds or more.

After testifying regarding his course of treatment, Petitioner also testified that in July of 2015 he was working light duty at Respondent's facility in the kitchen. He testified that he saw Dr. VanFleet at the request of Respondent, and that Dr. VanFleet recommended that an FCE be performed. He testified that he did not recall ever seeing Dr. VanFleet after the FCE was performed in October of 2015. He testified that he did, however, undergo another IME with Dr. Williams in December of 2015.

FINDINGS

On the date of accident, **December 14, 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.

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$64,131.96**; the average weekly wage was **$1,233.31**.

On the date of accident, Petitioner was **44** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of **$ALL AMOUNTS PAID** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$ALL AMOUNTS PAID** for other benefits, for a total credit of **$ALL AMOUNTS PAID.**

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner maintenance benefits of **$822.21**/week for **6 5/7** weeks, commencing **September 30, 2016 through November 15, 2016,** as provided in Section 8(a) of the Act.

Respondent shall initiate vocational rehabilitation pursuant to Section 8(a) of the Act.

Respondent is entitled to a credit for **all amounts paid under group health plan** under 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.

Melinda M. Rowe-Gillespie

Signature of Arbitrator

1/16/17

Date

ICArbDec19(b)

JAN 19 2017

Petitioner testified that in June of 2016 he went back to work and started retraining in order that he could get back onto the floor for his STA-1 position. He testified that he had classes, including training to talk to clients and how to take clients down who showed aggression, and that he also underwent CPR training. He testified that he participated in training including watching the videos, but did not do the physical things as he was told by management not to do so.

Petitioner testified that in July of 2016 his symptoms increased and that he was taking more pain medications including Tramadol, Advil and Tylenol in order to make it through work. He testified that the activities that caused an increase in symptoms included opening heavy doors, taking out the trash, doing unit searches and bending down. He testified that he tried to deal with "codes" but could not do it and that others tried to protect him. He testified that it was hard for him to clamp restraints on a client.

Petitioner testified that he saw Dr. Gornet in September of 2016, and that he did not change his restrictions. He testified that his last day worked was September 29, 2016. He testified that he has applied for disability through the State of Illinois and was currently not working. He testified that if Respondent was able to accommodate his restrictions, he would go back and try to work like he did before. He testified that if Respondent was not able to accommodate his restrictions, he was willing to work with vocational rehabilitation in order to find a job. He testified that his highest education was that of his high school diploma in 1986, and that he started working for Respondent in 1991 after he came out of the military.

On cross examination, Petitioner testified that he believed that he went back to work as an STA-1 in May and that he stopped working as an STA-1on September 29, 2016. He agreed that he underwent a performance evaluation between June and September, and that he met all of his objectives during that period of time according to his evaluations. He testified that people helped him out with his job from June to September, and that they watched over him because he used to watch over them.

On cross examination, Petitioner testified that he applied for non-occupational disability on September 29, 2016. When asked if he had applied for the alternative employment program through the State of Illinois, Petitioner responded that he did not know what that was. When asked if there was an open position for STA-2 (which is less physically demanding), Petitioner responded that he did not know. He testified that he applied for a promotion when he was hurting, but that he could not get the job.

On cross examination when asked how he heard about Dr. Gornet, Petitioner initially testified that he had a co-worker who had knee surgery and she purportedly told him about Dr. Gornet. He then testified that he did not know how he "got hooked up" with Dr. Gornet to perform his surgery. He thereafter testified that he knew Dr. Gornet through his co-worker, who said he did her knee surgery and that afterwards, her knee felt like it was brand new. He denied, however, that his attorney referred him to Dr. Gornet.

On redirect examination, Petitioner testified that with the evaluations, no one asked him about his pain levels. He testified that "they" did not care and just wanted him to work. He testified that when he went back to work from June to September, he took more pain medications to make it through the day. He testified that if a position opens while he is off on disability, he planned on applying for those positions.

Petitioner's Job Positions and CMS Job Description were entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of St. Anthony's Health Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen in the Emergency Room on December 15, 2011 for a back injury at work. It was noted that Petitioner slipped while trying to catch

a client, and that he now had increased low back pain. X-rays of the lumbar spine performed on that date were interpreted as revealing unremarkable radiographs of the lumbar spine. Petitioner was discharged and instructed to follow up with his primary care physician. (PX2).

The medical records of Dr. Randall Rogalsky were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on December 28, 2011, at which time it was noted that he presented with low back pain. It was noted that Petitioner was injured at Alton Mental Health when a client started to fall on December 14th (315 pounds), that he had complained of stiffness and electric-type symptoms in his low back and left leg and that he had been on light duty. The diagnosis was that of low back pain/left radiculopathy, and Petitioner was recommended to undergo an MRI and remain on light duty in the meantime. At the time of the January 16, 2012 visit, it was noted that Petitioner had a "very nice response" to light duties and that he had had no pain for 9 days and was quite pleased. The diagnosis was that of lumbar degeneration with L5-S1 disc protrusion but with no true sciatica. Petitioner was recommended to undergo physical therapy and continue light duty. (PX3).

The records reflect of Dr. Rogalsky that Petitioner was seen on February 6, 2012, at which time it was noted that he returned with improvement but with ongoing left sciatica. The diagnosis was that of clinical sciatica responding well to conservative measures. Petitioner was recommended to continue light duty. At the time of the March 2, 2012 visit, it was noted that Petitioner had done well over the last two weeks, was working with a 15-pound lifting restriction and had not been in any altercations. It was noted that Petitioner stated that his pain was improving and that he was undertaking normal day-to-day activities on a regular basis. The diagnosis was that of lumbar degeneration/mechanical low back pain. Petitioner's restrictions were modified to 50-pound lift restriction for one month. At the time of the April 2, 2012 visit, it was noted that Petitioner returned with no improvement on conservative measures. It was noted that Petitioner had had to avoid aggravating activities and had not been able to undertake his normal daily activities/physical therapy. The diagnosis was that of lumbar degeneration. Petitioner was referred to Piasa Pain Clinic and instructed to avoid aggravating activities. (PX3).

The records of Dr. Rogalsky reflect that Petitioner was seen on April 30, 2012, at which time it was noted that he was referred to the pain clinic at the last visit but there was a problem getting an appointment. It was noted that Petitioner continued to have unaltered symptoms. The diagnosis was that of lumbar degeneration. Petitioner was instructed to undergo a trial at the pain clinic and avoid aggravating activities. At the time of the May 30, 2012 visit, it was noted that Petitioner was working but had difficulty standing in the kitchen. It was noted that Petitioner had had no radicular symptoms and was using over-the-counter NSAIDs. It was noted that Petitioner had been unable to get accepted by any pain clinic despite the fact that his insurance carrier had approved pain clinic utilization. The diagnosis was that of lumbar degeneration/lumbar strain (chronic). Petitioner was instructed to continue over-the-counter NSAIDs, avoid aggravating activities if possible and continue working. (PX3).

Included within the records of Dr. Rogalsky was a Fax Transmittal Form dated June 12, 2012, noting that Petitioner requested a referral to Dr. Gornet. Also included within the records was a note dated June 27, 2012 noting that Petitioner had approval to go to Barnes Jewish Hospital for pain management. (PX3).

The MRI Lumbar Spine report dated January 10, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner underwent an MRI of the lumbar spine on January 10, 2012, which was interpreted as revealing (1) disc dessication and small central disc protrusion/herniation at L5-S1; (2) mild bilateral lower lumbar facet degenerative changes; (3) no other lumbar spine abnormality seen. (PX4).

The medical records of Barnes-Jewish Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on July 20, 2012 at the

referral of Dr. Rogalsky for consultation regarding treatment recommendations of low back pain. It was noted that Petitioner had had back pain since an injury at work in December 2011 in which he caught a person who started to fall and injured his low back. It was noted that Petitioner's pain was intermittent, ranged 2-5/10, was throbbing and burning with electric shock-like pain down the left lower extremity to the toes and that he also had occasional paresthesias/pain in the left foot. It was noted that Petitioner also reported mild neck pain to his arms, no numbness or weakness and indicated that the pain was tolerable. The assessment was that of other chronic pain, lumbosacral spondylosis without myelopathy, lumbago, sciatica and mild cervicobrachial pain. It was noted that given the left lower extremity radicular pain by history, a left lumbar L5-S1 SNRI was to be performed at the next visit. Petitioner was to continue using over-the-counter NSAIDs, continue the home exercise program and consider bilateral L3-S1 medial branch diagnostic block with potential radiofrequency in the future. (PX5).

The medical records of Dr. Yi were entered into evidence at the time of arbitration as Petitioner's Exhibit 6.[1] The records reflect that Petitioner was seen on August 7, 2012 for a LSNR injection. It was noted that Petitioner stated that his left lower extremity radicular pain and low back pain was slightly better and that Baclofen helped some of his pain and sleeping. Petitioner underwent a lumbar left L5-S1 selective nerve root injection on that date. At the time of the August 22, 2012 visit, Petitioner returned for the second left LSNR injection. It was noted that Petitioner's first injection provided significant pain relief, and that he stated he was almost pain-free until two days ago at which time he felt the pain start coming back. It was noted that Petitioner's pain was still in his low back radiating to the left foot and that he did some home exercises. Petitioner underwent a lumbar left L5-S1 selective nerve root injection on that date. (PX6).

The records of Dr. Yi reflect that Petitioner was seen on October 3, 2012 for his third left LSNR injection. It was noted that Petitioner's pain was reduced by 80%, and that he stated that he could walk much better and was doing "a lot better." It was noted that Petitioner still complained of significant numbness to the left foot, and that he also complained of axial low back pain. Petitioner underwent a lumbar left L5-S1 selective nerve root injection on that date. It was also noted that Gabapentin for left lower extremity/foot neuropathic pain and insomnia. At the time of the November 6, 2012 visit, it was noted that Petitioner reported significant relief from his last injection and that his pain was in the low back with radiation to the buttock area and was nagging and numbing in nature. It was noted that Petitioner continued to do home exercises and stretching and also used a TENS unit. It was noted that Petitioner was recommended to undergo a diagnostic lumbar medial branch block, bilateral L3-S1 and, if effective, schedule radiofrequency ablation in the future. Petitioner underwent the lumbar medial branch block, bilateral L3-S1 on that date. (PX6).

The records of Dr. Yi reflect that Petitioner was seen on December 10, 2012, at which time he underwent radiofrequency ablation of medial branch nerves (lumbar) for pre- and post-procedural diagnoses of other chronic pain and lumbosacral spondylosis without myelopathy. It was noted that Petitioner had significant but temporary pain relief of low back pain following medial branch blocks of bilateral L3-S1. It was noted that Petitioner had axial low back pain which was increased by activities, that he had no lower extremity radicular pain and that there were otherwise no interval changes. At the time of the January 11, 2013 visit, it was noted that Petitioner stated that he was doing a lot better now and that the radiofrequency significantly reduced his low back pain, probably 60-70%. It was noted that Petitioner stated that picking something up still exacerbated his low back pain, that he had no radicular pain, that his lifting limit was 50 pounds per his primary care physician and that he was applying for disability. (PX6).

The medical records of Alton Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent physical therapy for the

[1] Any highlighting that appears in the exhibit was not made by the Arbitrator.

timeframe of January 224, 2012 through February 28, 2012. At the time of the January 27, 2012 visit, it was noted that Petitioner's pain was 1/10 in the low back. At the time of the January 31, 2012 visit, it was noted that Petitioner stated that he did not have any back pain on that date. At the time of the February 2, 2012 visit, it was noted that Petitioner noted less frequent and less intense pain, that he noted only pain in the left lumbar if he made a sudden motion or with prolonged sitting, that he noted mild discomfort in the middle back on the left as well, and that he noted only one incidence of radicular symptoms in the past week. At the time of the February 7, 2012 visit, it was noted that Petitioner stated that he had been feeling better overall but was a little sore on that date due to slipping on the step and jerking his back. At the time of the February 8, 2012 visit, it was noted that Petitioner stated that his pain was 1/10 in his low back on that date and that he was concerned about going back to full duty at work. (PX7).

The records of Alton Physical Therapy reflect that at the time of the February 14, 2012 visit, Petitioner stated that he got a tingling sensation in his toes 3 or 4 times over the weekend. At the time of the February 16, 2012 visit, it was noted that Petitioner rated his pain at 0/10 on that date and that he had a small amount of pain in the middle back after traction the last session, but felt good after. At the time of the February 17, 2012 visit, it was noted that Petitioner noted pain in the lower back especially the hour after he left therapy, and that he had not been taking any medication related to his pain. At the time of the February 24, 2012 visit, it was noted that Petitioner noted more stiffness despite continuing with his home exercise program daily at home. At the time of the re-evaluation on February 28, 2012, it was noted that Petitioner stated that his pain had been in the lower back centrally especially with prolonged walking greater than 2½ hours and that he noted that if he was ambulatory for greater than that, he felt like his left leg would "give out." It was noted that based on Petitioner's clinical presentation, no further skilled care was necessary and Petitioner was discharged. (PX7).

The IME report of Dr. Keith Wilkey was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The report reflects that Petitioner was seen on December 17, 2012, at which time he described a fairly large individual who fell into him while helping him into a wheelchair. It was noted that Petitioner assisted the patient during the fall and subsequently pulled him to the ground himself, sustaining a twisting injury while performing an eccentric load which resulted in the immediate onset of low back pain as well as left leg pain. It was noted that Petitioner's pain was described as constant and dull, overall staying the same, and worse with activity such as doing yard work, sitting or doing any type of lifting. It was noted that Petitioner had a history of previous lumbar disease and that about every 2-3 years he had an intermittent backache, and that he indicated that he had not had any prolonged treatment by a physician. The assessment was that of (1) left leg radiculopathy, resolved; (2) lumbar herniated disc; (3) internal disc derangement L5-S1. It was noted that Dr. Wilkey opined that Petitioner had maximized his non-operative treatment modalities and should he fail the most recent medial branch block and not be able to return to work, then he would have to consider whether to proceed with surgery. It was noted that Dr. Wilkey indicated that if Petitioner did not proceed with surgery then he would be at maximum medical improvement and would require an FCE for final permanent restrictions, and that should he decide to undergo surgery then it would be up to his surgeon on how to proceed. (PX8).

The MRI Lumbar Spine was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. Petitioner underwent an MRI of the lumbar spine on June 6, 2013, which was interpreted as revealing (1) epidural lipomatosis of the L3/4, L4/5 and L5/S1 levels; (2) a central broad based herniation is seen at L5/S1 extending into the epidural fat but without evidence for dural displacement; (3) overall there is moderate L5/S1 and mild L4/5 central canal stenosis due to the epidural lipomatosis; (4) no discrete foraminal stenosis is detected. The records further reflect that Petitioner underwent another MRI of the lumbar spine on May 19, 2014, which was interpreted as revealing persistent annular tear and broad-based herniation at L5-S1; the herniation is slightly larger than on the previous exam and results in

ventral dural contact but no dural displacement or deformity; no central canal or foraminal stenosis is detected. (PX9).

The Myelogram Lumbar Spine report dated June 9, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that it was noted that Petitioner had low back pain down the left leg. The impression was that of no evidence of stenosis or definite nerve root cut off; correlation with CT scan would be of value. (PX10).

The CT Lumbar Spine Post Myelogram report dated June 9, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. Petitioner underwent a CT of the lumbar spine post-myelogram on that date, which was interpreted as revealing (1) degenerative disc disease L5-S1 probably disc herniation centrally, but minimal impact upon the dura with some foraminal narrowing; correlation with MRI scanning would be of value; (2) small disc bulge L4-5 but largely into epidural space. (PX11).

The Operative Report dated July 23, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. Petitioner underwent anterior decompression at L5-S1 and anterior lumbar fusion at L5-S1 on that date for a pre- and post-operative diagnosis of discogenic back pain. (PX12).

The Operative Report dated July 25, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. Petitioner underwent laminotomy at L5-S1 left and posterior fusion at L5-S1 on that date for a pre- and post-operative diagnosis of discogenic low back pain with foraminal stenosis. (PX13).

The CT Lumbar Spine report dated March 9, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 14. Petitioner underwent a CT of the lumbar spine on that date, which was interpreted as revealing (1) post-operative changes L5-S1 with some filling in of the lucency and perhaps developing towards fusion, although it cannot be absolutely confirmed that it was solidly fused at that time; (2) degenerative changes L4-5 with some degree of central and foraminal stenosis. (PX14).

The IME report of Dr. Timothy VanFleet was entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The report reflects that Petitioner was seen for an IME on September 15, 2015, at which time it was noted that he stated that he was helping a client get in his wheelchair and the client started to fall and fall towards him, grabbing him. It was noted that Petitioner indicated that he tried to hold the client (who weighed 350 pounds), and that he had an immediate electric shock across his back. After outlining Petitioner's treatment, Dr. VanFleet noted that Petitioner stated that initially he had some improvement after surgery, but that he had worsening of his symptoms once he tried to return to work with light duty. It was noted that Petitioner noted that he attempted to go back to work with light duty in January (2015) and described that since it was in his contract that he could only be on light duty for six months and had been on light duty twice since his work-related injury, he could no longer work. The report noted that Dr. Van Fleet's diagnosis was that of status post lumbar spinal fusion, and that it appeared that Petitioner underwent an operation on his lumbar spine for a work-related back injury. He noted that Petitioner demonstrated evidence of diminished capacity secondary to his failed back syndrome, which appeared to be related to the injury. The report noted that Dr. VanFleet opined that Petitioner's medical treatment incurred to date had been reasonable and necessary, but that no additional treatment was necessary. It was noted that Dr. VanFleet opined that Petitioner's prognosis was unknown but he gathered it to be poor considering a lumbar spinal fusion and a work-related injury generally would be associated with a poor outcome. It was noted that Dr. VanFleet indicated that Petitioner had reached maximum medical improvement and needed a functional capacity evaluation and restrictions could be placed on him based upon the results of the FCE as long as it was a valid study. It was noted that if it was an invalid study, then he would suggest returning Petitioner to work without restrictions. (PX15).

The Functional Capacity Evaluation dated October 27, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 16. It was noted that the required physical demand level was heavy (based on description provided by Petitioner) and that the performed physical demand level was medium. It was noted that Petitioner provided a maximal acceptable effort. (PX16).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 17. The records reflect that Petitioner was seen on March 1, 2013, at which time it was noted that he presented with a chief complaint of low back pain to both sides, particularly the left buttock, left hip and down the left leg to his foot and toes with numbness and weakness. It was noted that Petitioner stated that his current problem began on November 14, 2011, when he was assisting a patient who weighed at least 275 pounds. It was noted that Petitioner stated that he turned toward the patient and the patient began to fall suddenly, that he reached out to try to protect him from hitting the ground and bent forward rapidly, putting a sudden load on his arms and back. It was noted that Petitioner's symptoms were constant and worse with bending, lifting, twisting, prolonged sitting or standing and were better with lying down, and that he had left leg pain and numbness into his left foot but denied right leg pain. The records reflect that Dr. Gornet believed that Petitioner sustained a "disc injury" at L5-S1 and that he believed Petitioner's current symptoms were causally connected to his work-related injury as described. It was noted that Dr. Gornet agreed that Petitioner had maximized conservative measures and that he could continue working light duty. Surgical intervention was recommended (*i.e.*, an anterior lumbar fusion at L5-S1) and Petitioner was also recommended to undergo an MRI and CT of the lumbar spine. (PX17).

The records of Dr. Gornet reflect that Petitioner was seen on April 18, 2013, at which time it was noted that there were several miscommunications. It was noted that Petitioner should have continued with light duty rather than off work. Petitioner's MRI scan was also rescheduled. At the time of the June 6, 2013 visit, it was noted that the MRI of June 6, 2013 revealed an obvious central disc herniation and annular tear at L5-S1, which correlated with Petitioner's symptoms. Petitioner was recommended to undergo a steroid injection on the left at L5-S1 as well as a transforaminal injection, and he was referred to Dr. Boutwell for this. It was noted that if Petitioner was not improved, the consideration would be given to treating L5-S1 with surgery. Petitioner was continued on work restrictions, but it was noted that no light duty was available. At the time of the September 26, 2013 visit, it was noted that Petitioner had had some injections by Dr. Boutwell and that he was feeling somewhat improved. It was noted that Petitioner still had pain which at times affected his quality of life, and that he was not completely improved but was heading in the right direction. It was noted that Dr. Gornet believed that he did not want to move forward towards surgery if Petitioner continued to improve, but there was no way they would be able to determine whether he needed further help unless he was returned to full duty. It was noted that Petitioner was to have no direct patient contact. It was further noted that Petitioner understood that he was not at maximum medical improvement and that he still may require surgery. (PX17).

The records of Dr. Gornet reflect that Petitioner was seen on November 25, 2013, at which time it was noted that he tried to go back to work with no patient contact but his back continued to bother him. It was noted that Dr. Gornet believed that Petitioner would require a spinal fusion at L5-S1 and Petitioner was placed back on light duty. At the time of the February 24, 2014 visit, it was noted that Dr. Gornet agreed with Dr. Wilkey's statements. Dr. Gornet recommended a CT myelogram, a new MRI and an anterior lumbar fusion at L5-S1. At the time of the May 19, 2014 visit, it was noted that Petitioner's MRI scan "clearly" showed a central disc pathology/annular tear at L5-S1. It was noted that Petitioner had been approved for a CT myelogram and it would be expedited. Petitioner was allowed to continue to work light duty. At the June 9, 2014 visit, it was noted that the CT myelogram showed no significant issues with bony anatomy and that the current working diagnosis was discogenic pain at L5-S1. It was noted that Petitioner wished to proceed with surgery. Petitioner was allowed to continue to work light duty. (PX17).

The records of Dr. Gornet reflect that Petitioner was seen on August 14, 2014, at which time the staples were removed and it was noted that his radiographs looked excellent. It was noted that Petitioner's exam showed 5/5 strength in all groups and that he was essentially off all narcotics at that point. At the time of the September 11, 2014 visit, it was noted that Petitioner continued to do well overall. It was noted that Petitioner was asked to begin walking and abdominal strengthening. It was noted that his x-rays looked excellent. At the time of the November 3, 2014 visit, it was noted that Petitioner continued to make slow progress. Petitioner was recommended to begin physical therapy. It was noted that his radiographs looked excellent, that the CT showed early bone consolidation and that his exam was normal. At the time of the January 19, 2015 visit, it was noted that Petitioner had improved through physical therapy. Petitioner was released to light duty, and it was noted that when Petitioner next returned it was hoped that he was to be released back to work full duty with no restrictions. (PX17).

The records of Dr. Gornet reflect that Petitioner was seen on March 9, 2015, at which time it was noted that he stated that he had returned to work light duty but still had some symptoms in his back and buttocks that were problematic, particularly with a long day. It was noted that Petitioner had been unable to exercise or go to the gym due to what he felt was general exhaustion. It was noted that Petitioner's motor exam revealed 5/5 strength in all groups and his sensation was normal. It was noted that radiographs showed good position of his device with no instability on flexion/extension, and that the adjacent levels appeared to be health with no sign of collapse or other problems. It was noted that the CT showed good early reasonable consolidation, and that Dr. Gornet did not believe that Petitioner was completely healed. Petitioner was allowed to continue light duty work. At the time of the May 18, 2015 visit, it was noted that Petitioner stated that he was working light duty and it was noted that he had no new neurologic complaints. It was noted that lumbar films revealed good position of his device with no evidence of instability on flexion/extension, that there were no signs of early adjacent level failure and that the hardware appeared to be intact. It was noted that a CT scan was requested for July and that if it showed Petitioner was solidly healed and the screws appeared to be in good position, then he would probably be placed at maximum medical improvement. (PX17).

The records of Dr. Gornet reflect that Petitioner was seen on July 27, 2015, at which time it was noted that he continued to do well as long as he stayed within his restrictions which was a 25-pound lifting limit, alternating between sitting and standing as needed and no direct patient contact. It was noted that Petitioner was working in the kitchen. It was noted that the CT scan dated July 27, 2015 showed good reasonable bone consolidation. It was noted that as long as Respondent honored his restrictions, Dr. Gornet believed that Petitioner would be able to continue to be gainfully employed. It was noted that Petitioner was pleased with his progress. It was noted that Petitioner's restrictions were permanent and he was placed at maximum medical improvement. At the time of the July 25, 2016 visit, it was noted that noted that Petitioner was sent for another IME in spite of the fact that he had an FCE which "clearly" indicated limitations. It was noted that Petitioner was returned to full duty with no restrictions, which was heavy labor. It was noted that Petitioner was encouraged to try to work as best he could and that if he continued to have pain, a new MRI would be obtained. It was noted that Petitioner's current change in work activities was the cause of his increased symptoms and that his exam showed no focal changes. At the time of the September 29, 2016 visit, it was noted that Petitioner continued to have pain. It was noted that Petitioner stated that based on his seniority he should have a desk job available, but it was not being offered to him. It was noted that Dr. Gornet continued to believe that Petitioner was at maximum medical improvement. (PX17).

The medical records of Dr. Kaylea Boutwell were entered into evidence at the time of arbitration as Petitioner's Exhibit 18. The records reflect that Petitioner underwent a left L5/S1 epidural steroid injection on July 8, 2013 for a diagnosis of left lumbar radiculopathy. Petitioner also underwent a left L5/S1 epidural steroid injection on July 22, 2013 for a diagnosis of left lumbar radiculopathy. (PX18).

The Off Work Request Slips were entered into evidence at the time of arbitration as Petitioner's Exhibit 19. The Physician's Statement was entered into evidence at the time of arbitration as Petitioner's Exhibit 20.

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The IME report of Dr. Keith Wilkey was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report was duplicative of that as contained in Petitioner's Exhibit 8. (RX2; PX8).

The Dr. James Williams IME Report dated December 22, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Dr. James Williams IME Report dated June 2, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

The transcript of the deposition of Dr. James Williams was entered into evidence at the time of arbitration as Respondent's Exhibit 5. Dr. Williams testified that he is board-certified by the American Board of Physical Medicine and Rehabilitation and the American Board of Electrodiagnostic Medicine. He agreed that he was not a spinal surgeon, and testified that his practice focuses on the function of a patient. (RX5).

Dr. Williams testified that Petitioner's subjective complaints included pain in the sacral region and pain on the left more than the right in the gluteal region and also in the posterior thigh and the lateral aspect of his hip. He testified that Petitioner reported that he also had pain that felt like it was falling asleep that would start in the foot and then go all the way up his lower limb. He testified that Petitioner also reported being weak in his hands and his legs intermittently, and that the pain bothered him more on the left than the right before the surgery and now it was more on the right than the left. He testified that Petitioner's physical examination was essentially normal other than obviously the surgical scars, that he had some limitation in his lumbar flexion, that his extremity girth was essentially symmetric in the thigh and in the calf and that his neurological examination was normal. He testified that obesity or deconditioning can affect lumbar flexion. (RX5).

Dr. Williams testified that Petitioner's indication that the pain was worse on the left than the right before surgery and then worse on the right than the left after surgery was not explained by any obvious neurological problem, and that it was not explained by the imaging findings and the fact that he had apparent healing of his surgical site. He testified that there was no mention of any particular complications or damage that happened at the time of surgery to explain why he would have pain that would change locations, and that all it really told him was that his story was inconsistent. He testified that Petitioner did not have any objective evidence to corroborate his subjective complaints. When asked if he found any signs of symptom magnification, Dr. Williams responded that Petitioner had complaints of pain with simulated axial rotation but otherwise did not have any particular signs of magnification other than his complaints were just subjective without objective evidence to support them. (RX5).

Dr. Williams testified that Petitioner demonstrated fear avoidance behavior at the time of the examination, and that in his experience patients who had fear avoidance behavior self-limited their activity. He testified that he believed that he believed that at the time of his examination Petitioner had reached maximum medical improvement and that he should not have any specific restrictions on his activity. He testified that he believed that Petitioner should not be restricted as Dr. Gornet did, and that he did not believe that Petitioner's injury or surgery in any way limited his ability to defend himself in an altercation with a mental patient. (RX5).

Dr. Williams testified that he was also asked to review an FCE dated October 27, 2015 and that he authored an addendum outlining his thoughts and conclusions based on his review of that FCE. He testified that as a rehabilitation specialist he dealt with rehabilitation patients after injuries and/or surgeries, and that FCEs were one of the modalities he uses in assessing a patient's capabilities. He testified that FCEs can give some objective as well as subjective information about a patient's physical performance. He testified that you could not just rely on the recommendations that were in the FCE report without taking a look at the entire clinical picture. (RX5).

Dr. Williams testified that the significant things that he noted in the FCE report included the fact that the physical demand level was provided by the employee rather than the employer, that the rapid exchange grip was inconsistent and the cross reference validity was not valid so those should have been under a section of an indicator of submaximal effort, that Petitioner had extremely weak grip testing that was not addressed in the report, that there was no discussion about the fact that he demonstrated lifting abilities in the 20-30 pounds range when he is 5'11" and 255 pounds with no obvious anatomic pathology to explain why he would only be able to lift 20-30 pounds and the potential for misinterpretation of the heart rate changes. He testified that in his review of the FCE, there were multiple examples of submaximal effort. (RX5).

Dr. Williams testified that Petitioner demonstrated chronic pain behavior and that his review of Petitioner's FCE did not in any way change his opinion that Petitioner could return to work full duty without restrictions. He testified that the FCE identified the fact that Petitioner had submaximal effort and that he was not performing at a physical level of what you would expect somebody who was performing activity normally. (RX5).

On cross examination, Dr. Williams agreed that his board certification was in physiatry and agreed that he was not a spine surgeon nor is he licensed to perform spine surgery. He testified that he has not performed any spinal injections since 2001. He testified that in his own medical practice, it has likely occurred that he has placed a patient that had undergone an L5-S1 fusion with restrictions on their ability to work if they had problems with the union itself or if they had neurological injury associated with the procedure or with the injury prior to the procedure. He agreed that he was aware that orthopedic and neurosurgeons in the area had restricted patients who had undergone fully healed L5-S1 lumbar fusions based on post-operative symptoms. (RX5).

On cross examination, Dr. Williams agreed that he did not himself perform FCEs. He agreed that he had not had any classes or training on how to perform an FCE, but testified that he had post-residency education regarding FCEs, how to interpret them and how to evaluate the results. He agreed that FCEs could be a valid measure of a patient's ability to do things on the day of the exam and that they were used to develop treatment programs for patients. He agreed that FCEs were used to measure the physical abilities of patients before or after a rehabilitation program and that FCEs could also be used to modify an existing rehabilitation program. (RX5).

On cross examination, Dr. Williams admitted that he was not aware of Petitioner's exact employment status as of July of 2015. When asked if it would be reasonable for the treating surgeon to order a new MRI scan if a patient returned to work and the work activities resulted in an increase in pain and symptoms, Dr. Williams responded that he would not necessarily agree and that in this case, there was no mention of neurological symptoms. He testified that it would make more sense to do a CT scan if you were looking at the integrity of the fusion. (RX5).

On cross examination, Dr. Williams testified that his definition of failed back syndrome referred to someone who had had surgery and continued to have pain and problems after the surgery, and that it was non-specific. He denied ever speaking to Dr. VanFleet with respect to any of the work that he did on the case. He agreed that the physical demand level at which Petitioner performed as documented in the

FCE was consistent with the restrictions placed by Dr. Gornet. He agreed that in his practice he has seen FCEs where the examiner would conclude that the results were unreliable, and that this was not the conclusion of the therapist in this case. (RX5).

On cross examination, Dr. Williams agreed that Petitioner's ability to restrain a mentally ill inmate in a security situation could be negatively impacted by his physical condition. He agreed that the ability to take an inmate to the ground to protect himself and others could be negatively impacted by his current condition. He agreed that he was not rendering opinions as to whether Petitioner could physically perform the job of an STA-1 safely. He testified that Dr. Gornet's note from July of 2016 that reflected an increase in symptoms after returning to full duty did not affect his opinion in any way. (RX5).

On cross examination when asked if there would have been anything that could have been in the FCE that would have changed his opinion, Dr. Williams responded affirmatively and testified that if the FCE would have shown clear consistent effort, then it would alter his opinions. He testified that some of Petitioner's heart rate changes showed what he considered maximal effort and some of them did not, and that was why you needed to look at all of them. (RX5).

On redirect examination, Dr. Williams testified that pain was a subjective symptom. He testified that if a person was deconditioned it was better for them to not restrict activities, and that activity itself over and above what you were used to doing was by definition uncomfortable. (RX5).

The Alton Mental Health Performance Evaluation was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The report reflects that for the period of evaluation of June 28, 2016 through August 28, 2016, Petitioner met the various objectives for his position and the General Appraisal of Employee Performance noted that Petitioner met his expectations according to his supervisor. (RX6).

The Mentor Evaluation Forms were entered into evidence at the time of arbitration as Respondent's Exhibit 7. The records reflect that the various individuals completing the forms found Petitioner to have performed at a Satisfactory and/or Excellent level. (RX7).

The Dr. Williams' Signature Page was entered into evidence at the time of arbitration as Respondent's Exhibit 8.

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has proven that his current condition of ill-being is causally related to the injury of December 14, 2011, particularly in light of the medical evidence in the case. The Arbitrator notes that not only did Dr. Gornet opine that Petitioner's condition of ill-being was related to the underlying accident, Dr. Wilkey also opined that Petitioner had a history that was consistent with a symptomatic degenerative condition. (PX8; RX2). The Arbitrator further notes that Dr. VanFleet opined that Petitioner "demonstrate[d] evidence of diminished capacity secondary to his failed back syndrome. This all appears to be related to the injury." (PX15). Even the IME reports of Dr. Williams demonstrated that he diagnosed Petitioner with chronic low back and lower limb pain status post surgically successful instrumented L5/S1 fusion without current evidence of lumbosacral radiculopathy. (RX3). Accordingly, the Arbitrator finds that there does not appear to be a dispute between any of the physicians in this case that Petitioner's lumbar injury was caused by the workplace incident and that the lumbar fusion was necessary to treat the injury. As a result thereof, the Arbitrator finds that Petitioner has proven that his current condition of ill-being is causally related to the injury of December 14, 2011.

With respect to disputed issues (L) pertaining to maintenance benefits and (O) pertaining to vocational rehabilitation, given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

Under Section 8(a) of the Act, an employer "shall...pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." 820 ILCS 305/8(a).

The Arbitrator finds that Petitioner is entitled to maintenance benefits and vocational rehabilitation as the restrictions imposed by Dr. Gornet and as set forth in the FCE recommended by Respondent's own IME physician, Dr. VanFleet, are reasonable based upon the medical evidence in the case. As the evidence demonstrates that Respondent is not accommodating such permanent restrictions, the Arbitrator hereby finds that Petitioner is entitled to such maintenance and vocational rehabilitation benefits.

The Arbitrator notes that Dr. Wilkey and Dr. VanFleet noted that an FCE was appropriate for setting Petitioner's restrictions. (PX8; RX2; PX15). The evidence reflects that Respondent scheduled the FCE with an examiner of its own choosing, who apparently concluded that Petitioner could not meet the physical requirements of the STA-I job. The FCE noted that the required physical demand level was heavy (based on description provided by Petitioner) and that the performed physical demand level was medium. (PX16). It was also noted that Petitioner provided a maximal acceptable effort. (PX16). The Arbitrator notes that Dr. Williams agreed that he was not rendering opinions as to whether Petitioner could physically perform the job of an STA-1 safely. (RX5). Despite the Arbitrator's reservations about the veracity of Petitioner's testimony at the time of arbitration as to the circumstances under which he was referred to Dr. Gornet, the Arbitrator finds that Respondent is bound by its FCE as recommended by Dr. VanFleet, which is consistent with the restrictions imposed by Dr. Gornet.

As a result thereof, the Arbitrator concludes that Respondent shall pay maintenance benefits of $822.21/week, commencing September 30, 2016 through November 15, 2016. Respondent shall also initiate vocational rehabilitation services pursuant to Section 8(a) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Brennan,

Petitioner,

vs. NO: 16 WC 11666

City of Harvey,

Respondent.

18IWCC0436

DECISION AND OPINION ON REVIEW

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

The Commission herein affirms and adopts the Arbitrator's finding as to all issues. The Commission modifies only to add boilerplate language as to payment of the PPD award. ("Respondent shall pay the PPD accrued from April 9, 2016 to May 17, 2018 and shall pay the remainder of the award, if any, in weekly payments").

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 23, 2017 is hereby, otherwise, affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 150 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 30% loss of Petitioner's person as a whole. Respondent shall pay the PPD accrued from April 9, 2016 to May 17, 2018 and shall pay the remainder of the

award, if any, in weekly payments.

18IWCC0436

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

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

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

DATED: JUL 16 2018
o-5/17/18
DLG/jsf
045

David S. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRENNAN, CHRIS
Employee/Petitioner

Case# **16WC011666**

CITY OF HARVEY
Employer/Respondent

18IWCC0436

On 10/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% 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:

4262 ROMANEK & ROMANEK
DARON ROMANEK
ONE N LASALLE ST SUITE 425
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CHRIS BRENNAN
Employee/Petitioner

v.

CITY OF HARVEY
Employer/Respondent

Case # 16 WC 11666

Consolidated cases: ____

18IWCC0436

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **July 19, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0436

FINDINGS

On **June 30, 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 **$69,209.40**; the average weekly wage was **$1,330.95**.

On the date of accident, Petitioner was **37** 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 **$25,731.99** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$25,731.99**. By stipulation, Respondent shall be given a credit for payments made pursuant to PEDA from 07/01/14 through 09/18/15. Respondent is entitled to a credit of **$4,121.44** under Section 8(j) of the Act for medical benefits paid.

ORDER

Respondent shall pay reasonable and necessary medical services of **$697.17**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any and all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

By stipulation, Petitioner received temporary total disability benefits of **$887.31/week** for **29 weeks**, commencing **9/19/15** through **4/8/16**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$25,731.99** for temporary total disability benefits that have been paid. Respondent shall further be given a credit for payments made pursuant to PEDA from 07/01/14 through 09/18/15.

Respondent shall pay Petitioner permanent partial disability benefits of **$721.66/week** for **150** weeks, because the injuries sustained caused the **30%** loss of the person as a whole, as provided in Section 8(d)(2) of the Act

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

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

Signature of Arbitrator

10-23-17
Date

OCT 23 2017

18IWCC0436

FINDINGS OF FACT

Christopher Brennan ("Petitioner") testified that he worked for the City of Harvey ("Respondent") on June 30, 2014 as a lieutenant in the fire department. Petitioner began his employment with Respondent on November 15, 2005.

Petitioner testified that on June 30, 2014 he responded to a call and had been picking up from a structure fire when a tree limb came loose during a windstorm and struck Petitioner in the back of the head. The branch knocked the helmet from Petitioner's head and Petitioner fell to the ground on his knees. Petitioner did not lose consciousness, did not have any cuts and did not bleed as a result of being struck in the back of the head by this branch.

After being struck by this branch and falling to his knees, Petitioner put his helmet back on and finished off his work at the fire site. Petitioner continued to work after this incident when he responded to other calls for assistance, such as typical emergency responses for things like downed power lines.

On 6/30/14, Petitioner received medical attention at Ingalls Immediate Occupational Health in Flossmoor. The doctor at Ingalls Occupational Health discharged Petitioner that same day and allowed Petitioner to return to full duty without accommodation. Petitioner returned to work and his neck felt stiff and sore. A report was made that same date. Rx1.

Petitioner's shift ended on 7/1/14 at 7:00 a.m. and Petitioner testified that he left the firehouse around 7:30 a.m. Petitioner took Advil because of neck pain. On 7/1/14, Petitioner also saw doctors at Ingalls, who treated Petitioner for head contusion following being hit by a tree in the head at work. Rx2. He was diagnosed with a head injury and released to full duty work. Following this visit, Petitioner said he had a headache and a new onset of right shoulder pain. That same afternoon, Petitioner ran some errands with his wife and during that time Petitioner felt dizziness, electric shooting pain in his head and nausea. He later presented to Loyola's university clinic from home with complaints of acute onset of headache and shoulder pain. Px1, Rx3. Petitioner related his work accident, treatment and symptoms. Assessment was head injury. Petitioner went to the Loyola Immediate Care Center and had x-rays taken of his right shoulder and neck, along with a head CT scan. The doctor at Loyola took Petitioner off work from 7/1/14 and allowed him to return to work on 7/5/14. Px1.

On 7/8/14, Petitioner saw his primary doctor, Dr. Gregory Ozark at Loyola University Medical Center. Dr. Ozark took Petitioner off work until Petitioner felt headache-free for one week and diagnosed Petitioner with post-concussive syndrome. Px1. On 7/14/14, Petitioner returned to Dr. Ozark reporting ongoing headaches but he had slept good and felt a lot better. Petitioner was continued off work until Petitioner felt headache-free for one week. On 7/28/14, Petitioner returned to see Dr. Ozark and seemed to be getting better and then after a six (6) hour car trip and an attempt to exercise, Petitioner's headaches returned. Dr. Ozark prescribed Amitriptyline for headaches and referred Petitioner to a neurologist at Loyola University Medical Center.

On 8/17/14, Petitioner saw Dr. Holdridge, neurologist, at Loyola University Medical Center. Petitioner reported feeling a dull, achy sensation every day in his head, along with slight, intermittent nausea and exertion with being on his feet for more than a couple of hours. Petitioner felt it was chronic. Petitioner was referred for physical therapy for vestibular rehabilitation.

On 8/19/14, Petitioner began vestibular rehabilitation at Loyola University Medical Center. Therapy involved a general warm-up, balancing and strengthening exercises and neck or spine mobilization.

On 8/21/14, Petitioner's physical therapist reported that Petitioner had a constant headache that increased with activity and that his neck felt stiff, tight and tender. Petitioner explained that he had an increase in headache pain after walking in the zoo with his family for two hours.

On 9/19/14, Dr. Holdridge noted Petitioner's headaches had remained the same but Petitioner developed severe neck pain about three weeks prior during physical therapy and that neck pain has been constant since. Petitioner had numbness in both hands that came on sporadically. Petitioner continued to have dizziness.

Petitioner explained that he had constant, daily headaches that worsened with loud noises or bending. Petitioner also discussed with Dr. Holdridge that while at a recent wedding he had difficulty reading and focusing words and text. Thereafter, Petitioner's headache worsened throughout the day. Petitioner said he had never experienced an episode like this prior to the work accident. On 9/19/14, MRI of the neck showed mild, multi-level spondylosis without spinal cord compromise.

On 10/17/14, Petitioner returned to Dr. Holdridge and reported he continued to get dizzy after balance training during physical therapy. Dr. Holdridge also noted that chaotic noise and position remained very aggravating to Petitioner. Petitioner related that he skipped activities with his son because he felt that an increased heart rate for any consistent period of time caused him problems. Petitioner did report that his neck felt much better.

On 11/14/14, Petitioner returned to see Dr. Holdridge and reported he had begun to have periods during the day when he did not have headaches. However, noise and physical therapy exacerbated pain. Petitioner continued to have dizziness, especially after physical therapy and cognitive fatigue.

On 1/23/15, Petitioner saw Dr. Matthew McCoyd and said his main issue had become nightmares and he never had this problem the accident. On 1/23/15, Dr. Holdridge noted that Petitioner continued to have light-headedness, especially when Petitioner stood up quickly or during physical therapy and continued to have difficulty with balance, especially with his eyes closed and when he stood on one leg. Around this time, Petitioner went to see his niece in an ice show and for three days after the ice show the intensity of Petitioner's headaches increased due to noise. Petitioner said during this time, he continued to experience light-headedness, especially when Petitioner stood up quickly or during physical therapy.

On 3/26/15, Petitioner saw Dr. Jeffrey Kramer for an examination at the request of Respondent. Rx4. Dr. Kramer diagnosed Petitioner with post-concussion syndrome with chronic post-concussion headache and vestibular impairment. The doctor further found that the etiology of Petitioner's current condition was related to his work accident. Dr. Kramer found subjective complaints were supported by objective findings. Dr. Kramer concluded that Petitioner had yet to reach maximum medical improvement and that Petitioner would benefit from a change in his medications. Dr. Kramer determined that Petitioner could work sedentary duty, could not work on heights, could do desk work or light maintenance work but bending over or lifting above shoulder level should be limited to fifteen pounds.

Petitioner testified that during the week before 3/27/15, Petitioner had family in from Wisconsin for a day and he took his family to the Art Institute and socialized with them and the activities of that day wore Petitioner out and Petitioner felt as if he had been beaten by a baseball bat. Petitioner said he could not bend forward or pick things up from the ground without exacerbating his symptoms. Px1. Petitioner said he had no such problems

before the work accident. Petitioner was eventually prescribed Topamax to help control nightmares but Petitioner eventually discontinued this due to tingling.

On 5/8/15, Dr. Holdridge noted that Petitioner's head pain had not changed and continued to be located occipitally, bilaterally and radiated forward. Petitioner's headaches continued at the same daily pain level and more severe headaches continued to be triggered by noise and positional changes.

Dr. Holdridge noted Petitioner had not had any physical therapy since it was discontinued or terminated. Eventually, on 5/12/15, Petitioner resumed therapy after it was approved. Eventually, Dr. Holdridge changed Petitioner's medication to Bystolic. Px1. Bystolic had no effect on Petitioner's headaches. Petitioner testified he felt that the combination of Effexor and Amitriptyline helped reduce his nightmares and make them less frequent but Effexor did not eliminate Petitioner's nightmares. In June 2015, Petitioner informed Dr. Holdridge that when his headaches arrived, they came faster and stayed longer. Petitioner also noted that physical therapy helped him but at a slow rate. Petitioner reported that his headaches continued to intensify since the Elavil dosage had been decreased.

On 9/4/15, Petitioner testified that when he saw Dr. McCoyd, he had switched from Amitriptyline to Protriptyline and this worsened Petitioner's headaches. Petitioner stopped taking Bystolic because Bystolic made Petitioner overly dizzy with standing. There continued to be a positional nature to Petitioner's headaches because Petitioner's headaches worsened when Petitioner bent forward.

On 9/25/15, Petitioner saw Dr. Arthur Itkin, neurologist, at the request of Respondent. Rx5, Rx7. Impression was very mild concussion and subsequent sequalae of posttraumatic head injury due to the work accident. he felt Petitioner's complaints were entirely subjective but that is was not unusual in the case of post-concussive syndrome. The doctor felt most of Petitioner's disability related to his exertional headaches. He did not believe Petitioner was at MMI and that he would continue to improve in post concussive symptoms as he had with vestibulopathy.

On 10/26/15, Petitioner returned to Dr. McCoyd and complained of severe headaches, with noise still a significant contributor. The doctor summarized a normal neurologic exam. Diagnosis was post-concussion syndrome. The doctor found Petitioner compliant with all treatment to date but doubted whether any additional treatment would provide any benefit. On 11/4/15, Loyola psychiatric evaluation described extensive pre-existing history of depression and alcohol abuse disorder prior to the head injury. Px1, Px3. Diagnosis was PTSD, major mood disorder, anxiety (mild, recurrent) and sleep-wake disorder.

On 2/12/16, Petitioner returned to Dr. McCoyd, who noted ongoing headaches that remained throbbing and sharp. Dr. McCoyd prescribed a Medrol dose pack. Dr. McCoyd noted that Petitioner has headaches more than fifteen times a month without relief from abortive or prophylactic therapy. Dr. McCoyd felt Petitioner may benefit from Botox for his chronic migraine headaches. The doctor felt Petitioner's symptoms would be chronic in nature and did not anticipate any significant improvement.

On 3/12/16, Dr. Itkin issued an addendum opinion at the request of Respondent. Rx6. Dr. Itkin agreed with Dr. McCoyd that Petitioner had not exhausted all available options and agreed that Petitioner might benefit from Depakote or Botox therapy for chronic headaches. Petitioner testified that he currently uses Depakote but that Botox was not authorized. Dr. Itkin opined that Petitioner reached MMI and improved completely as it related to his work-related injury. Dr. Itkin felt that Petitioner could be suffering from chronic migraines; and, potentially, Petitioner could have a psychological component, including, but not limited to, conversion disorder

and even malingering. Dr. Itkin did not have an opinion as to whether conversion disorder or malingering are contributing to Petitioner's subjective complaints. Dr. Itkin concluded that from a neurologic standpoint Petitioner's return to work as a fireman would be unrestricted as it related to his work accident.

On 3/28/16, the pension board sent Petitioner to Dr. Norman Kohn, a neurologist, for an examination. Px2. Dr. Kohn concluded that Petitioner's symptoms and clinical findings had been consistent with persistent post-concussion syndrome with headache. The doctor further noted that although Petitioner's headache syndrome had no specific correlated physical findings or objective tests, Dr. Kohn pointed out that Petitioner "...had abnormal vestibular tests, however, which represent an objective and reproducible measure of injury to the vestibular system. While this does not by itself imply headache, it indicates the severity of [Petitioner's] head injury." Dr. Kohn opined that Petitioner's condition has no associated specific objective physical findings, it is not possible in this examination to rule out symptom magnification or malingering. However, Dr. Kohn found no basis for inferring either of those. The doctor concluded that Petitioner's headache symptoms were the result of the workplace injury and he could not find other contributing causes. Dr. Kohn agreed with Dr. Itkin and Dr. Kramer that Petitioner's persistent post-concussion syndrome with headache prevented Petitioner from working as a firefighter. The doctor expected Petitioner's condition to be permanent and Dr. Kohn did not identify any treatment that could reasonably be help Petitioner return to his pre-injury job.

On 4/5/16, the pension board sent Petitioner for an examination with Dr. Timothy McGonagle. Px3. Dr. McGonagle discussed a discrepancy between Petitioner's signed statement as to whether Petitioner's helmet was knocked forward or off at the time of the accident compared to subsequent histories given. Dr. McGonagle believed that Petitioner suffered a mild, traumatic brain injury/concussion. Dr. McGonagle noted that Petitioner had a brief post-trauma period largely asymptomatic, followed by the onset of concussion symptoms several hours later. Dr. McGonagle found this scenario slightly unusual but certainly acceptable. Dr. McGonagle felt that Petitioner's set of symptoms (mild headache, light sensitivity and sleep dysfunction) should last for three (3) to ten (10) days and then resolve. Dr. McGonagle concluded that mild head trauma occurring to one with pre-existing significant problems with depression and alcoholism making him statistically more at risk for developing prolonged post-concussion symptom complex. The doctor did not believe Petitioner could return to his regular job duties and that he was "disabled."

On 6/1/16, the pension board sent Petitioner for the third and final exam to Dr. Lawrence Robbins. Px4. The doctor noted Petitioners history of accident and that he had headache and dizziness with posttraumatic chronic daily headache, nausea and sonophobia. The doctor noted Petitioner had been diagnosed with post dramatic or post concussive syndrome with daily headaches. At the time of the examination, Petitioner noted that dizziness and headaches were somewhat improved. At that present time, Petitioner continued with headaches approximately 3 to 4 out of 10 with the same triggers increasing such headaches. The doctor noted Petitioner had been sober for three years. He noted Petitioners prior history of depression with past suicidal ideation and question of mild bipolar spectrum. The doctor felt Petitioner was very honest and forthright with no signs or symptoms of malingering or embellishing. The doctor believed Petitioner was legitimately having posttraumatic daily headaches and migraines with dizziness. He did not believe it if you could return to job as a firefighter. The doctor believed that Petitioner's condition would continue into the future but he could not say that it was permanent. Condition was caused by the work accident. The doctor believes Petitioners pre-existing conditions would be a tendency toward headaches and depression. The doctor believes that the work accident pushed his nervous system over into chronic headaches and dizziness. The doctor recommended further treatment with His neurologist and consideration of Other medications and treatments.

On 1/23/17, Petitioner saw Dr. McCoyd for the final time. Petitioner told Dr. McCoyd on January 23, 2017 that he continued to have chronic migraine headaches for more than fifteen days a month, with some of these

headaches lasting more than four (4) hours a day. He continued to recommend Botox. He opined Petitioner's symptoms were chronic in nature. Petitioner testified that he has not seen a doctor since he last saw Dr. McCoyd on 1/23/17.

Today, Petitioner believes he has lost his career because he no longer works as a firefighter and currently Petitioner is an assistant scoutmaster with his son's Boy Scout troop and Petitioner does volunteer work with non-releasable birds of prey. Petitioner presently talks to people once a week about hawks and owls for a little while. Petitioner thinks he had a non-diagnosed concussion in his mid-twenties that he recovered from. Petitioner had occasional sinus headaches before June 30, 2014. Petitioner did not suffer a head injury since June 30, 2014.

Regarding nightmares, Petitioner testified that his nightmares were and continue to be brutal. Petitioner thrashes in his sleep and moans. During these nightmares, Petitioner has woken up screaming more than once. On one occasion during the middle of the night, Petitioner punched his wife in the back and this caused Petitioner to get up and go to sleep on the couch. Petitioner's nightmares began sometime during November, 2014 and his nightmares regularly disturbed his sleep and woke Petitioner up 3-4 times a night.

Regarding his condition at the time of trial, Petitioner stated that he sleeps more poorly than he did prior to his injury. Even during nights that are nightmare-free, Petitioner still wakes up two to three times a night a couple of days a week and then Petitioner struggles to get back to sleep. During the nights when Petitioner has nightmares, Petitioner might sleep two hours during those nights. Petitioner had no trouble sleeping prior to June 30, 2014.

Petitioner testified he can no longer provide physical training and cross-training for first responders and firefighters as he did prior to June 30, 2014 because of the positional and exertional nature of those activities. Petitioner's work in teaching and training firefighters involved the hands-on teaching of situational awareness training and stress inoculation training. Petitioner has been unable to teach any firefighters since June 30, 2014 because Petitioner said he is incapable of taking part in these activities, stating that he cannot get into the positions and be hands-on with his students. Petitioner said he had no difficulty regularly engaging in these teaching activities before June 30, 2014.

Petitioner testified that today he keeps a very open schedule due to his post-concussion syndrome because Petitioner must accept the fact that at any given point in time he will need to take a nap because he cannot keep engaging in activities. When Petitioner takes a nap, he lays down in his bedroom with the lights off, the curtains drawn, the fan going and Petitioner covers his face with a pillow for two hours.
When Petitioner attends events with a large group of people, Petitioner wears earplugs in an attempt to avoid the triggering event of the noise from a large group of people causing a headache.

Today, Petitioner has headaches three to four days a week, with the worst headaches being two to four hours in duration. As of the time of trial, Petitioner said he had not had a headache-free day since his work accident occurred. Petitioner explained that the difference between his headaches and migraine headaches is that Petitioner's migraine headaches require Petitioner to put life on pause and to lay down and cover his head, while Petitioner's headaches are just a constant presence. The shortest duration for Petitioner's migraine headaches can be one hour to ninety minutes. Petitioner's regular headaches do not go away.

Petitioner did some blogging and writing about firefighting before June 30, 2014. Since Petitioner's June 30, 2014 injury he has attempted to write both fiction and non-fiction, but Petitioner has a desktop of half-started things. Petitioner explained that he has a desktop of half-started things because Petitioner as Petitioner believes

he struggles to get anything done. Petitioner spends a lot of time staring out of his window or napping. Petitioner testified that he does hike today to avoid weight gain but when he hikes he can break as needed.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator had an opportunity to observe Petitioner's demeanor at trial and to listen to his testimony. The Arbitrator finds that Petitioner was credible insofar as he was very candid and knowledgeable in explaining the circumstances surrounding his accident. Further, Petitioner was highly credible and articulate in his testimony regarding his medical treatment and stated level of disability and/or functional limitations he notices.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that his current condition of ill-being is causally related to his undisputed work accident. In so finding, the Arbitrator has considered Petitioner's credible and unrebutted testimony, along with all of the medical records and evidence.

Dr. Timothy McGonagle opined that Petitioner suffered a mild traumatic brain injury/concussion due to the work accident and that his concussion related symptoms occurred due to the head trauma, but are persistent due to the underlying depression and anxiety. Dr. Norman Kohn opined that Petitioner's headache symptoms were caused by the workplace injury. Dr. Kohn did not identify any significant additional contributing causes. In this regard, the Arbitrator notes that it is well-settled that so long as the work accident is causative factor in a claimant's condition of ill-being, causation may be found. as applied here, Petitioner has proven that the work accident was a causative factor in the development of his post-concussive syndrome, chronic headache and vestibulopathy.

Dr. Lawrence Robbins opined that the onset of Petitioner's disabling condition occurred following the work accident. Respondent's first Section 12 examiner, Dr. Jeffrey Kramer opined that Petitioner had post-concussion syndrome with chronic post-concussion headache and vestibular impairment and that the etiology of that condition was the work accident. Rx4.

Respondent's second Section 12 examiner, Dr. Arthur Itkin, opined that he could be suffering with chronic migraines and the potential cause of Petitioner's chronic migraines could have a psychological component including, but not limited to, conversion disorder and even malingering. Rx6. Dr. Itkin concluded that Petitioner's subjective complaints and thus his present medical condition were not directly related objectively to the work accident.

The Arbitrator adopts the opinions of Drs. McGonagle, Kohn, Robbins and Kramer in this matter as credible and more persuasive. The Arbitrator recognizes that disability as it relates to Petitioner's claim for pension benefits is different than the disability standard under the Act, the Arbitrator is entitled to weigh and rely on these doctors' opinions insofar as they provide medical opinions as to the cause(s) and etiology of Petitioner's condition and symptoms. In finding the opinions of Dr. Itkin unpersuasive and therefore entitled to less weight, the Arbitrator makes the following findings. Dr. Itkin did not review Dr. Kramer's report and was the only doctor to find the possibility of malingering. Further, the doctor's opinion that Petitioner's condition could have a psychological component to it does not adequately address or explain whether the work accident played a role

in Petitioner's condition. In light of the foregoing, the Arbitrator concludes that Petitioner's current condition of ill-being is causally related to his work accident.

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

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies on same in concluding that Petitioner has proven by a preponderance of the evidence that the medical services that were provided to Petitioner were reasonable and necessary and further that Respondent has not yet paid all appropriate charges.

The Arbitrator has reviewed Petitioner's Exhibit No. 5 (Bills from Loyola University Medical Center) and Petitioner's Exhibit No. 6 (Exhibit setting forth which entities paid Loyola University Medical Center). The Arbitrator notes the outstanding balances and that the charges are related to reasonable and otherwise necessary care and treatment for Petitioner's related condition.

The Arbitrator has reviewed Petitioner's Exhibit No. 7 (Bills from Loyola University Physician Foundation) and Petitioner's Exhibit No. 8 (Exhibit setting forth which entities paid Loyola University Physician Foundation). The Arbitrator notes the outstanding balances and that the charges are related to reasonable and otherwise necessary care and treatment for Petitioner's related condition. These dates of service include: March 27, 2015, May 8, 2015, June 19, 2015, September 4, 2015, October 26, 2015, February 12, 2016 and May 10, 2016.

These bills submitted and alleged as unpaid by Petitioner correspond to the related dates of medical treatment discussed, *supra*. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Respondent shall pay Loyola University Medical Center **$40.05** for reasonable and necessary medical services and Loyola University Physician Foundation **$657.12** for reasonable and necessary services, as provided in Sections 8(a) and 8.2 of the Act. This finding does not mean that Respondent is to pay again any of the aforementioned bills that Respondent has paid since the hearing date of this case, July 19, 2017. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies on same in addressing the nature and extent of Petitioner's causally related injuries. When Petitioner last saw Dr. McCoyd on 1/23/17, Dr. McCoyd noted that it may be reasonable to assume Petitioner's current symptoms, based on their duration and intractable nature, will be chronic in nature and the plan was to continue to treat symptoms. Px1. Petitioner has not returned since but continues to obtain medication through Dr. McCoyd.

Dr. Norman Kohn stated on 5/13/16 that Petitioner has a permanent condition and Dr. Kohn could not identify treatment that could reasonably be expected to return Petitioner to work as a firefighter. Of note, Botox injection treatment was not approved. Petitioner has not treated with Dr. McCoyd or any other doctor or sought any additional treatment since 1/23/17 and Petitioner's current condition has stabilized and plateaued; therefore, Petitioner's claim for disability, if any, is ripe for adjudication.

In determining permanent partial disability, Section 8.1(b) provides that permanent partial disability shall be established using the following criteria: (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.

Regarding (i), the Arbitrator notes that the parties did not submit an American Medical Association (AMA) impairment rating; therefore, in light of the foregoing, the Arbitrator assigns no weight to the AMA impairment rating.

Regarding (ii), Petitioner's unrebutted testimony is that he is no longer working as a firefighter and he has lost his career as a firefighter because Petitioner's post-concussion syndrome symptoms of headaches, migraine headaches and dizziness will not allow Petitioner to perform the duties of a firefighter. Dr. Kohn did not expect Petitioner to return to work as a firefighter. Px2. Dr. McGonagle concluded that Petitioner suffers from a disabling condition that prevents him from performing the full and unrestricted duties of a firefighter. Px3. Dr. Robbins stated that Petitioner's severe problems with headaches and dizziness would preclude Petitioner from performing full and unrestricted firefighting duties. Px4. The Arbitrator finds that the weight of the evidence shows that Petitioenr cannot return to work as a firefighter and therefore, assigns more weight to this factor.

Regarding (iii), Petitioner's age at the time of the injury was 37 years. The Arbitrator finds that this factor may increase Petitioner's level of permanent partial disability because he may live with the effects of his post-concussion syndrome longer due to a longer work-life expectancy. The Arbitrator assigns more weight to this factor.

Regarding (iv), or future earning capacity, the evidence shows that Petitioner can no longer work as a firefighter and he cannot teach or train firefighters because Petitioner cannot get in any positions to demonstrate and this will not allow Petitioner to be hands-on with his students. Since Petitioner has lost his career and can no longer work as a firefighter, there is evidence that Petitioner's future earning capacity has been and will be impaired. The Arbitrator assigns more weight to this factor.

Regarding (v), evidence of disability corroborated by the treating medical records, the Arbitrator weighs this factor in favor of Petitioner. Petitioner's uncontroverted testimony was detailed and credible regarding his disability relative to Petitioner's post-concussion syndrome. Petitioner explained how his headaches and migraine headaches have severely limited his abilities to move and to move with exertion. Petitioner also explained how he alters his life because certain things, such as noise, will trigger headache events that will force Petitioner to nap with immediacy. The Arbitrator finds Petitioner's reporting of his symptoms to be consistent with Petitioner's final visit with Dr. McCoyd, who described Petitioner's symptoms as intractable and chronic in their nature.

Considering all of the factors pursuant to Section 8.1(b) in conjunction with Section 8(d)(2), the Arbitrator concludes that the work accident caused injury to Petitioner resulting in permanent partial disability of **30%** of a man as a whole as a loss of trade under Section 8(d)(2). Respondent shall pay Petitioner permanent partial disability benefits of **$721.66/week** for **150 weeks**, because the injuries sustained caused **30%** loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

Signature of Arbitrator

10-23-17
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SUSANA MIRELES,

Petitioner,

vs. NO: 11 WC 23368

QUAKER OATS/PEPSI CO.,

Respondent.

18IWCC0437

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

The Commission finds that Petitioner has proven that her current condition of ill-being is causally related to the accident of February 17, 2011, wherein Petitioner was severely injured when her arm became trapped in a piece of machinery, requiring surgery to repair, with two subsequent revision surgeries. The Commission modifies the Arbitrator and finds that Petitioner's current condition of ill-being is causally related to her work accident, and that she is awarded medical expenses for the third surgery and related treatment, additional temporary total disability between December 8, 2015 and December 20, 2015, and that she suffered permanent partial disability of 15% of the right arm.

The Commission finds that Respondent should pay for the third surgery with Dr. Lee, a plastic surgeon. After Petitioner underwent the initial two surgeries and desensitization therapy, she continued to have pain, as well as an unsightly scar. The third surgery was for an excision of the wound scar, as well as removing additional scar tissue that had formed. (Px5) Prior to the surgery, Petitioner was complaining of itching and pain. (T. 23) Respondent denied the treatment

on the basis that this procedure was identical to her second surgery, and that she had not undergone conservative therapies prior to moving forward with surgery. (Rx1 and Rx2) However, the utilization review is not supported by any peer review studies and/or the Official Disability Guidelines. Petitioner credibly testified that between the second and third surgeries, she had on-going problems that were causally related to her initial work injury on February 17, 2011. The Commission finds that the third surgery and related treatment was medically appropriate and causally related to the injury. In light of this finding, the Commission finds that Petitioner is entitled to temporary total disability for the time she missed work due to the third surgery.

The Commission further finds that the cases cited by the Arbitrator, *Abel Acosta v. Leinenweber Roofing, Inc.*, 06 WL 68301, and *James Schoeberl v. Hale Trucking*, 2007 WL 2257158, 20007 WL 2464253 are, given the additional surgery, more analogous to the instant case.

In *Acosta*, the Petitioner suffered uncontested accidental injuries resulting in full to partial thickness burns. Petitioner underwent a skin graft, followed by OT, PT, work conditioning and work hardening. Petitioner eventually underwent 2 additional surgeries related to hypersensitivity from the dorsal radial and dorsal ulnar sensory neuromas. He continued to have soreness. The Petitioner was awarded 20% loss of use of the right arm.

In *Schoeberl*, the Petitioner suffered uncontested accidental injuries when he fell from his truck resulting in a deformity at the sight of injury and residual scar to his left arm after a hook ripped through his arm. Petitioner underwent initial surgery and at least one revision surgery. Petitioner's arm remains sensitive to the touch. The Petitioner was awarded 20% loss of use of the left arm.

In the instant case, the Petitioner testified that she continues to experience pain (T. 26) and suffers from two significant scars along her forearm. Petitioner has undergone 3 surgeries – one repair and two scar revision surgeries – to try to reduce her pain and improve the cosmetic appearance of her arm. Petitioner further testified she never sustained injuries to her right arm prior to the undisputed work incident. (T. 17) Based on the above, an award of 15% loss of use of the right arm is more appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $589.07 per week for a period of 7 6/7 weeks, commencing February 18, 2011 through March 6, 2011; June 27, 2013 through July 23, 2013; and December 8, 2015 through December 20, 2015, 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 $530.16 per week for a period of 37.95 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 15% loss of use of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary unpaid medical expenses under §8(a) of the Act, including but not

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limited to $1,850.00 to Danville Polyclinic, as well as the outstanding bills related to the third surgery and attendant care for University of Chicago Hospital, University of Chicago Physicians Group, Athletico, Indiana Hand to Shoulder, Southern Illinois Hand, and the University of Chicago, subject to the fee schedule in §8.2 of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent 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 $26,700.00. 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: JUL 16 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 060518
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MIRELES, SUSANA M
Employee/Petitioner

Case# **11WC023368**

18IWCC0437

QUAKER OATS/PEPSICO
Employer/Respondent

On 11/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
BRIDGETTE VAN TUYLE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0522 THOMAS MAMER & HAUGHEY LLP
BRUCE E WARREN
30 MAIN ST SUITE 500
CHAMPAIGN, IL 61820

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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

Susana M. Mireles
Employee/Petitioner

v.

Quaker Oats/PepsiCo
Employer/Respondent

Case # 11 WC 23368

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **September 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

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On **2/17/2011**, 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 $**45,947.20**; the average weekly wage was $**883.60**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

Petitioner is entitled to temporary total disability benefits commencing **2/18/2011** through **3/6/2011 and 6/27/2013** through **7/23/2013,** a period of **6 1/7 weeks**.

Respondent shall be given a credit of $**1,519.01** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,813.24** for other benefits, for a total credit of $**3,332.25**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$1,850.00** to **Danville Polyclinic** as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$589.07/week** for **6 and 1/7 weeks**, commencing **2/18/2011** through **3/6/2011** and **6/27/2013** through **7/23/2013**, as provided in Section 8(a) of the Act. Respondent shall be given a credit of $1,519.01 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$530.16/week** for **25.3 weeks**, because the injuries sustained caused the **10% loss of the right arm,** as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **February 17, 2011** through **September 21, 2016** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

November 19, 2016
Date

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NOV 28 2016

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner was injured in an undisputed accident on February 17, 2011 while working for Respondent as a machine operator. At that time she was cleaning a granola bar machine at the end of her shift. Petitioner testified, and the medical records corroborate, that while her arm was inside of the machine, the machine engaged and her arm was caught inside of the machine. Her arm was stuck inside of the machine while she called for help. Petitioner was taken by ambulance to Provena United Samaritans Medical Center. The emergency room records indicate that Petitioner suffered a work injury resulting in a deep laceration which was too deep for the emergency room physician to close. Petitioner testified, and the emergency room records corroborate, that Petitioner's wound was dirty from the oil in the machine. She was taken off work. (PX 1)

Petitioner underwent a debridement and closure of laceration with placement of a drain performed by Dr. Bowen at Danville Polyclinic on February 18, 2011. According to the History and Physical Exam Petitioner's physical examination revealed an actively bleeding deep laceration with a significant flap on her right forearm. However, her range of motion in her arm was good as well as her hand strength. An x-ray noted an extensive soft tissue laceration seen in her forearm. Dr. Bowen further noted that while Petitioner's laceration was long it was not in the muscle as she was neurovascularly and musculotendinously intact on examination.(PX 2)

On February 22, 2011, Dr. Bowen examined Petitioner in follow-up noting that she was lightheaded and nauseous. He recommended that she continue taking the prescribed antibiotics. (PX 2)

As of March 2, 2011 Dr. Bowen noted Petitioner had good function of her hand and wrist with no significant nerve or muscular damage. However, she was still healing. He also noted an area on her wrist described as "raw" from an abrasion. (PX 2)

Petitioner returned to work on March 6, 2011 on a light duty basis. (PX 2)

Petitioner continued following up with Dr. Bowen through March 21, 2011 at which time she was released to full duty. When last seen Petitioner complained of discomfort and hypoesthesia just distal to the area of the wrist. Petitioner's primary concern was scarring but, otherwise, Dr. Bowen felt Petitioner was doing well, especially considering what it looked like initially (ie. very dirty with ragged edges). At that time Dr. Bowen noted it was completely healed at the skin with minimal scarring. The abrasion at Petitioner's wrist looked worse than the actual laceration but he felt it should heal in time. (PX 2)

Petitioner testified that, thereafter, she continued experiencing pain in her right upper extremity. Upon the recommendation of the workers' compensation claims adjuster, Mickey

Martin. Petitioner sought treatment at the Indiana Hand to Shoulder Center with Dr. Baltera on June 28, 2011. The records indicate that she was experiencing stabbing pain and tenderness to palpation at her scars. Dr. Baltera noted a scar over the dorsoradial side of her wrist just proximal to the wrist joint as well as a second scar starting about mid-forearm on the anterior surface and then extending ulnarly and proximally up to just below the antecubital fossa and elbow joint. Dr. Baltera recommended Petitioner wait to see if there was any improvement in her symptoms over time, noting that it could take up to one year for all of Petitioner's swelling to go down and the scars "mature." To assist, he ordered desensitization, gel pads, and scar pads. If Petitioner failed to improve with those modalities, he felt she might need a neuroma incision. (PX 3)

Petitioner underwent an occupational therapy visit at the Hand to Shoulder Therapy Center on June 28, 2011. Her case manager was in attendance. She was instructed in the use of heat, massage, and a gel sleeve to be used at night. (PX 3)

Per the doctor's orders, Petitioner followed up with Dr. Baltera on December 27, 2011. At that time she was still complaining about hypersensitivity over the proximal scar and its appearance. Petitioner was non-tender about the distal scar but the proximal scar was thick and hypersensitive with a mildly positive Tinel's noted. Dr. Baltera found no evidence of loss of sensation distally, however. Her shoulder, wrist, and finger range of motion was normal. Dr. Baltera described the scar as having reached a quiescent state with some hypersensitivity over the sensory nerves running through the scar but no evidence of nerve laceration or sensory loss distally. He recommended desensitization with the therapist and re-evaluation in six months. Dr. Baltera noted that if hypersensitivity persisted, Petitioner could consider an operation involving the exploration, neurolysis, and excision of any sensory nerves. In the interim, Petitioner was advised she could continue working without any restrictions. (PX 3)

Petitioner presented to the Hand to Shoulder Therapy Center on December 27, 2011 where they reviewed Petitioner's desensitization program. (PX 3)

Approximately ten months later, on September 11, 2012, Petitioner sought a second opinion with Dr. Nash Naam at Southern Illinois Hand Center. Dr. Naam noted numbness and tingling in area of Petitioner's scar as well as hypersensitivity and tenderness. Petitioner's complaints included intermittent numbness and tingling in the area of the scar associated with hypersensitivity and tenderness. Petitioner reported having to "itch" the scar several times and feeling like it was ugly. Petitioner also had another scar along the radial side of the right distal forearm that she didn't like either but she had no pain or discomfort associated with that scar. Petitioner denied any numbness or tingling of the fingers or any loss of sensibility of her right hand. Petitioner was also complaining of left wrist pain with Dr. Naam noting her job required heavy manual use of both wrists. On examination of the 10 cm. oblique scar along the volar ulnar aspect of Petitioner's proximal forearm, there were some areas of positive Tinel's signs along the most distal part of the prominent, but sunken, scar. Sensory examination revealed normal sensibility proximal and distal to the scar. The scar along the radial side of the right distal forearm was not tender or hypersensitive. Dr. Naam's impression was a tender scar of the volar ulnar aspect of the right proximal forearm, neuromas of the scar of the proximal right forearm, osteoporosis of the left wrist (per x-ray), and possible left carpal tunnel syndrome. In light of the fact Petitioner's desensitization program and conservative approach had not helped her

symptoms Dr. Naam recommended surgery involving excision and revision of the right proximal forearm scar with excision of neuromas and possible neurolysis of superficial nerves. He recommended no treatment for the right distal forearm scar. (PX 4)

Petitioner continued treating with Dr. Naam, returning on January 7, 2013 for a pre-operative evaluation. Dr. Naam noted that Petitioner's distal forearm scar wasn't causing her any problems nor was it thickened or tender. He saw no evidence of neuroma in that scar. According to his notes, the doctor and Petitioner had some discussions regarding possible surgery on the distal forearm scar with the doctor explaining his physical examination findings and, based upon them, he felt it should be left alone as any surgery would be primarily for cosmetic reasons and not functional reasons. He also explained that when he sought approval for surgery it had been for the excision of the neuromas and revision of the proximal forearm scar but nothing on the distal forearm scar and workers' compensation had approved the proximal forearm surgery. Petitioner told the doctor that had she known that, she would have gone elsewhere. Based upon that it was felt surgery should be canceled and Dr. Naam advised Petitioner that she might prefer to go elsewhere. No further appointments were made. (PX 4)

Petitioner returned to Dr. Naam's office on April 23, 2013 regarding surgery stating that she wished to proceed with it. On exam she had localized points of tenderness thought possibly due to small neuromas. Dr. Naam issued an off work slip effective May 8, 2013. (PX 4)

Petitioner did not proceed with surgery per Dr. Naam.

Rather, on May 21, 2013, Petitioner returned to see Dr. Baltera. Dr. Baltera noted he had not seen Petitioner for several years but that she had returned due to persistent right forearm pain after a work-related injury. It was his understanding that Petitioner was working full duty and denying any significant numbness or tingling in her hand or wrist. Her primary complaint was the persistent pain through the scar. Dr. Baltera felt her symptoms and exam were most consistent with a neuroma of the small sensory branches through the volar forearm, noting "It has been 2 years despite desensitization and she is having persistent pain." On examination he noted a long oblique scar through the volar ulnar aspect of Petitioner's mid forearm. He noted no loss of sensation distal to it but mild tenderness through the volar at 50% of the scar, with maximal tenderness in the mid 1/3 of the scar even to light touch, which he felt consistent with neuroma. Petitioner had full finger and wrist range of motion and was neurovascularly intact distally and all tendon function was intact. Dr. Baltera injected the area of Petitioner's scar for diagnostic purposes. Dr. Baltera noted slight improvement in pain and no loss of sensation. Dr. Baltera recommended an operation involving exploration of the scar, excision of the hypertrophic scar, exploration of the wound for neuroma, and excision and burying of the neuroma. Dr. Baltera also noted that "if neuromas are identified, even if they are an incontinuity and these are excised, it should help her pain, but it may leave her with some loss of sensation of the volar forearm distal to the scar, and she [is] willing to accept this loss to resolve her pain." Pending surgery Petitioner was allowed to continue working with no restrictions. (PX 3)

On June 27, 2013, Dr. Baltera performed surgery on Petitioner's right upper extremity in the form of a right forearm scar revision, excision of two neuromas, and burying of the neuromas. Dr. Baltera noted that he identified and transected two cutaneous nerves within the wound. He then resected the nerves proximal to the wounds so that they would be out of the zone

of injury. Petitioner was diagnosed with a right forearm hypertrophic scar with neuromas. Petitioner was advised she could return to work with no use of her right hand. Dr. Baltera also noted that Petitioner could return to work on July 10, 2013 with a 5 lb. restriction and no repetitive use of the right hand. She was to return to see him on July 23, 2013. (PX 3)

Petitioner returned to the Hand to Shoulder Therapy Center on July 11, 2013. (PX 3)

On July 23, 2013, Dr. Baltera re-examined Petitioner. Petitioner was reporting no improvement in the hypersensitivity of her scar which the doctor suspected might be due to central nervous system imprinting, noting she had been having pain in that area for an extended period of time. He also noted that she complained of some numbness distal to her scar, as expected, from excision of the neuromas. Petitioner was to continue with scar massage and desensitization. He felt it could be months before she would notice improvement in her scar discomfort. Dr. Baltera noted that Petitioner could return to work on July 23rd with a five pound restriction and full duty beginning July 29, 2013. (PX 3)

Petitioner returned to work for Respondent on July 29, 2013 per Dr. Baltera's release. (PX 3)

Petitioner followed up with Dr. Baltera on September 3, 2013, at which time he noted she did not have any significant improvement in her symptoms as she still had some hypersensitivity to the skin distal to her scar. Petitioner's scar was noted to be slightly hypertrophic but improving with full finger range of motion, full wrist range of motion and a negative Tinel's over the scar. She was advised to continue with scar massage and desensitization. She was instructed on skin desensitization with different types of cloth. He did not think further surgery would be necessary. She was to return in three months. (PX 3)

Petitioner did not return to see Dr. Baltera as requested. (PX 3)

On April 25, 2014 Dr. Baltera authored a letter to Mickie Martin. He noted that at the time of the last visit with Petitioner in September Petitioner didn't feel her symptoms were significantly improved as compared to prior to surgery and, therefore, the doctor recommended continued observation and a final check in three months. Dr. Baltera noted that Petitioner was scheduled to return and see him that week but had called to cancel the appointment stating she was having no further problems and no further pain. Therefore, he felt she was at maximum medical improvement and she was released from care. (PX 3)

Petitioner underwent no further treatment for her right upper extremity between her September 3, 2013 examination with Dr. Baltera and her examination with Dr. Lee on December 4, 2014, fourteen months later. Petitioner testified that during that time period she continued to experience symptoms of pain in her right forearm. She testified that the pain was shooting and, at times, felt like a stab. She described it as feeling similar to fiberglass on one's skin as it would hurt and itch.

Petitioner then sought treatment from Dr. Lee at the University of Chicago Medical Center on December 4, 2014. Dr. Lee noted that she was two years post injury to her right arm and had two substantial scar deformities which were very embarrassing to her. Petitioner had

normal motor and sensory examinations of her hand. Dr. Lee recommended Vitamin D daily, Avosil for the hyper-pigmented scars, and scar revision surgery. (PX 5)

Approximately ten months later, Petitioner returned to Dr. Lee at University of Chicago on October 2, 2015 as she had telephoned his office in August expressing the desire to proceed with surgery; however, the doctor wished to re-examine her first. Dr. Lee noted that Petitioner had undergone two previous surgeries on her arm, the first as a repair and the second for a neuroma release. Petitioner reported her pain was improved since the neuroma surgery but she still experienced intermittent shooting pains a few times a day. She reported no results with use of Avosil. While Petitioner reported her arm did not affect her activities of daily living, she was unhappy with its appearance and bothered by the intermittent pain. On exam the doctor noted a 5 cm. contracted scar to the right forearm with no hypertrophy but positive paresthesia with Tinel's testing over the scar. Her hypothenar muscles were equal bilaterally. Dr. Lee recommended an EMG to evaluate nerve function. Dr. Lee opined that she would likely need scar revision surgery. (PX 5)

Petitioner underwent an EMG on November 5, 2015. The EMG was a normal study. On November 19, 2015, Dr. Lee again recommended a surgery involving a scar revision and possible nerve repair. (PX 5)

Petitioner was re-examined by Dr. Lee on November 19, 2015 who noted no changes in his examination. He still recommended surgery. (PX 5)

Petitioner underwent further surgery on December 8, 2015. Dr. Lee performed an excision of the wound scar, removal of subcutaneous scar tissue and complex wound closure. Petitioner's scar was located on the proximal third of her forearm overlying the flexor carpi ulnaris muscle. Dr. Lee noted the scar was 12 cm. in length and stuck to the fascia of the muscle with evidence of scar entrapment of the medial antebrachial cutaneous nerve at the scar. He excised the scar down to the muscle fascia. Dr. Lee examined Petitioner's distal radial scar also but noted that he did not perform any surgery on the second scar for risk of developing neurological complications. Some visible hypertrophic scarring was noted. (PX 5)

By letter dated December 10, 2015 Dr. Lee was advised by Sedgwick Utilization Review that the scar revision surgery he had recommended was being denied as it was not medically certified. (RX 1) According to the Peer Review Report of December 8, 2015 the surgery suggested by Dr. Lee was deemed not medically certified because Dr. Trotter, the reviewing physician had not seen any detailed evidence of "weeks-month(s)" of a "recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure, including desensitization therapy." Dr. Trotter's report notes that he reviewed Dr. Lee's reports of November 5, 2015 and November 19, 2015. (RX 2)

Petitioner testified that because the surgery was denied by Workers' Compensation, she used her group health insurance to pay for it.

Petitioner testified that she experienced some relief in her symptoms following this surgery. On December 17, 2015, Dr. Lee re-examined Petitioner noting that she was doing well with minimal pain. Petitioner advised the doctor that Respondent did not have light duty

available for her and she was wondering when she could return to work full duty which required the ability to lift 30 lb. boxes. Petitioner also inquired about treatment for varicose veins. On examination Petitioner had some mild residual swelling on her arm. She was advised to use Avosil when her steri-strips fall off and told she could return to work on December 4, 2015. They also discussed treatment for her varicose veins. She was to return in six weeks. (PX 5)

Petitioner testified that she returned to work on December 20, 2015.

Petitioner returned to see Dr. Lee on January 22, 2016. She reported she was doing well but having some "pins and needles feeling" to her scar. She denied any sharp shooting pains and was using the Avosil. Petitioner reported working and having no trouble lifting heavy boxes. Dr. Lee's exam showed a well healed right arm scar with mild hyperpigmentation but no hypertrophy or point tenderness. Petitioner was advised to continue her therapy for desensitization and her use of Avosil. She was to return in six to eight weeks. (PX 5)

Petitioner attended physical therapy at Athletico Accelerated Rehab from February 8, 2016 through April 4, 2016. The physical therapist noted that Petitioner was back at work full-time which required heavy lifting which was difficult to do due to stabbing pain and paresthesia. The physical therapy records noted that Petitioner began experiencing a stabbing sensation in her right forearm, diminished sensitivity, and needle like stabs of pain along her scar. Petitioner was noted to be right hand dominant. (PX 6)

Petitioner did not return to see Dr. Lee as he had requested. (PX 5)

Petitioner's case proceeded to arbitration on September 21, 2016. The only disputed issues were medical bills, temporary total disability and the nature and extent of Petitioner's injury. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that she is no longer treating for her right arm condition. She continues to work for Respondent; however, she is now in the sanitation department which she described as being a lot easier and less strenuous. Petitioner still has two scars from the work accident, one on her right wrist and another on her right forearm. Petitioner testified that she is right handed, had no prior issues with her right upper extremity prior to February 17, 2011, and has not suffered any injuries to her right upper extremity since the 2011 work accident.

Petitioner testified that while the surgery performed by Dr. Lee helped her pain, she still has pain and numbness in her right forearm. She testified that the pain she experiences is intermittent and sharp, like broken glass on her skin. Petitioner testified that she experiences pain during every day activities both at home and at work, such as touching her scar while crossing her arms or while emptying garbage bins at work. At the time of arbitration Petitioner denied having any pain; however, she testified that if she "bangs it" or leans it on a table, she notices a shooting pain in her forearm. Petitioner testified that she is claiming permanency as a result of her injury and not disfigurement.

After proofs were closed the parties submitted their proposed decisions. Additionally, the attorneys for both parties emailed the Arbitrator advising her that they both were jointly requesting that RX 3, 4, 5, and 6 be withdrawn. The Arbitrator has noted the withdrawal on

Respondent's Exhibit List (AX 4) and pulled the exhibits but kept them as part of the record and labeled them "withdrawn."

The Arbitrator concludes:

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

Respondent disputed the medical expenses from The University of Chicago Hospital, The University of Chicago Physician's Group, and Athletico (all stemming from the third surgery performed by Dr. Rafael Lee) based upon reasonableness and necessity. In support thereof it tendered a utilization report. Dr. Lee's surgery was denied by the workers' compensation carrier because there was a lack of evidence of recent conservative, non-operative treatment, such as desensitization therapy.

The Arbitrator finds that the medical care recommended and undertaken by Dr. Rafael Lee was not medically necessary. As a basis for this conclusion the Arbitrator cites to Respondent's Exhibits 1 and 2, the utilization review report and the supporting peer review. Additionally, the Arbitrator notes that all subjective testing done by Dr. Lee prior to his surgery was negative, including a detailed EMG/NCS study of the forearm. Dr. Lee asserted in his records that he expected to find a neurological deficit in the arm, but did not. The Arbitrator notes the Petitioner had already had a scar revision by Dr. Baltera which was successful and that Dr. Lee's treatment merely duplicated the earlier procedure. Lastly, the Arbitrator notes the Petitioner made nearly identical complaints at trial as to those she made to Dr. Lee before the third surgery, indicating the surgery had not accomplished anything except further revising the scar. Petitioner's attorney stated to the Arbitrator that she is not pursuing this case as one for disfigurement. Consequently, a second revision of the scar would have no effect on the outcome of this matter and would be clearly unnecessary.

For the reasons stated, the Arbitrator denies all benefits arising or claimed from Dr. Lee's treatment. Specifically, all associated medical bills, contained in Petitioner's Exhibit 7 and consisting of those from the University of Chicago Medicine Hospital, University of Chicago Physicians and Athletico, are denied.

The Arbitrator awards Petitioner the bill from Danville Polyclinic in the amount of $1,850.00. Respondent, if it wishes, may resolve that bill directly with the provider pursuant to the Fee Schedule. Respondent is given a general credit for all payments made on any and all bills contained in (Petitioner's Exhibit 7), whether those bills were paid through the workers' compensation claim or by the Respondent's group program.

Petitioner is denied her request for travel expenses/mileage with regard to her treatment at the Indiana Hand to Shoulder Center in Indianapolis, Indiana, her treatment in Effingham, Illinois, and her treatment at in Chicago. Petitioner provided no testimony regarding the issue of

mileage despite its being placed in issue. Additionally, as Petitioner personally chose to seek treatment in Effingham, Illinois at Southern Illinois Hand Center and Chicago, Illinois at The University of Chicago Medical Center, those travel expenses are denied.

Issue (K): What temporary total disability benefits are in dispute?

Petitioner is awarded temporary total disability benefits from February 18, 2011 through March 6, 2011 and June 27, 2013 through July 23, 2013, a period of 6 1/7 weeks.

Respondent primarily disputed liability for temporary total disability benefits for the period of time following Petitioner's surgery with Dr. Lee at University of Chicago (December 8, 2015 through December 20, 2015). Consistent with her determination above regarding the reasonable and necessity of Petitioner's treatment with Dr. Lee, the Arbitrator declines to award temporary total disability benefits for that period of time.

Respondent shall pay Petitioner the sum of $589.07 per week for 6 1/7weeks for temporary total disability benefits from February 18, 2011 through March 6, 2011 and June 27, 2013 through July 23, 2013. Respondent shall be given a credit of $1519.01 for temporary total disability benefits that have been paid for the period Petitioner was off work from February 18, 2011 through March 6, 2011 and June 27, 2013 through July 23, 2013.

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

As a result of Petitioner's injury, Petitioner sustained a deep laceration to her right forearm and a distal radial scar due to an abrasion. She has undergone three surgeries on the right forearm scar. The distal radial scar has required no surgery and, as noted by Dr. Naam in May of 2013 it wasn't causing her any problems nor was it thickened or tender. He saw no evidence of neuroma in that scar. He felt she needed no surgery on the distal wrist scar in terms of function. If she did proceed with any surgery on the distal radial scar it would be for purely cosmetic reasons. Treatment thereafter focused on the right forearm scar.

Petitioner waived any claim for disfigurement, electing instead to pursue permanent partial disability.

Petitioner testified that she still suffers from intermittent pain and diminished sensitivity in her dominant, right upper extremity. She was released to full duty work with no permanent restrictions. She testified to intermittent pain and diminished sensitivity in her right forearm on occasion. Petitioner has good function of her fingers, hand, wrist, and arm. Petitioner's arm does not interfere with her activities of daily living. While she is currently working in a different position, no evidence was presented that the move was due to her injury herein. No evidence of loss of earning capacity was presented. Petitioner is currently 64 years old.

The Arbitrator is cognizant of the Commission's decision in *Abel Acosta v. Leinenweber Roofing, Inc.*; however, she finds it factually distinguishable from the instant case. In that case, a claimant suffered burns to his right arm at work, underwent one surgery for an excision of a neuroma, and subsequently continued suffering from scarring, sensitivity to touch, and numbness/itching. However, the claimant's scarring in *Acosta* was more extensive than

Petitioner's herein, the Arbitrator noting, *inter alia*, that Acosta's scarring extended into his hand. Additionally, unlike the instant case, the claimant in *Acosta* had limited range of motion of his right forearm in supination and pronation, numbness of the right hand, and weakness in his grip. The Commission awarded claimant 20% loss of use of his right arm for his work injury. *Abel Acosta v. Leinenweber Roofing, Inc.*, 06 IWCC 0025, 2006 WL 68301. Similarly, the Arbitrator finds the Commission's decision in *James Schoeberl v. Hale Trucking*, 07 IWCC 0793, 2007 WL 2257158, 2007 WL 2464253 (awarding claimant 20% loss of use of his left arm after suffering a soft tissue laceration to his left forearm which resulted in hypersensitivity and a possible neuroma) distinguishable as the claimant therein had more extensive residuals from his injury such as sensitivity to touch "and everything," spasms in his hand where his hand clenches and will not let loose, arm weakness, weight restrictions, and trouble supporting his body with his arms.

Based upon the foregoing, Respondent shall pay Petitioner the sum of $530.16/week for 25.3 weeks, as provided in Section 8(e) of the Illinois Workers' Compensation Act because the injuries sustained caused permanent disability to Petitioner's right arm, to the extent of 10% thereof.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TRACIE GAINER,

Petitioner,

vs. NO: 12 WC 21754

STATE OF ILLINOIS,

Respondent.

18IWCC0438

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, statute of limitations, medical and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below but adopts the Decision of the Arbitrator, as to the Statement of Facts, which is attached hereto and made a part hereof.

The Commission finds that Petitioner met her burden of proof regarding accident, and that she gave proper notice within the statute of limitations. The Commission reverses the Arbitrator regarding accident and finds that Petitioner's current condition of ill-being is causally related to her alleged work accident, and that she is entitled to medical expenses and permanent partial disability of 5% of a person as a whole.

The Petitioner has worked as a personal assistant caring for patients for approximately 17 years, 13 of which have been in the State of Illinois. She has been working with her current patient since July of 2009. (T. 47-48) Her current patient is a large man in a wheelchair who is close to 300 pounds. He is completely disabled and is incapable of walking and has no motor skills. He needs complete assistance with everything. (T. 10-12) Petitioner gave extensive testimony regarding multiple transfers and assisting her patient from bed to wheelchair to chair, in and out of the car, and in and out of the bath. She initially performed these duties 11.5 hours per day, and then it was reduced down to 7.5 hours per day. (T. 61-62) She had no assistive devices, and occasional help from her daughter. She sought medical treatment on June 14, 2012, wherein she was diagnosed with a lumbar sprain/strain with radiculopathy. By August of 2012, she was referred to a pain specialist. At that time, her treating physician believed she suffered from cervical and lumbosacral spondylosis, discogenic cervical radiculopathy, discogenic lumbar

radiculopathy, lumbo-sacral facet arthropathy and spinal stenosis and recommended cervical and lumbar epidural injections. In January, 2013, her treating physician rendered a causation opinion directly linking her condition to her work-related repetitive lifting. (Px4)

The Illinois Court of Appeals recognizes two alternative criteria which are set forth by Professor Larson for fixing the date when the injury manifests itself. The first is the time at which the employee can no longer perform his job. The other is the onset of pain which necessitates medical attention. In adopting the former of these, this court concluded the time at which both the fact of the injury and the causal relationship become plainly evident is a question of fact and the "onset of pain and the inability to perform one's job, are among the facts which may be introduced to establish the date of injury." *Oscar Mayer & Co. V. Industrial Comm'n*, 176 Ill. App. 3d 607, 610 (1988) *citing Peoria County Belwood Nursing Home v. Industrial Comm'n*, 138 Ill. App. 3d 880, 887 (1985). Petitioner continued to do her job, however in June, 2012, the pain became too great for her to continue and she sought medical care.

The Petitioner testified she began experiencing problems which "she knew" were related to her working with a large heavy patient, that she experienced for approximately two years prior to seeking medical attention. (T. 75-76) She testified that prior to July, 2009, when she began working with her patient, she had no problems with her neck or back, and that by 2012, when she sought medical treatment, it was because the pain was unbearable. (T. 34, 32) Petitioner is claiming her injuries are a result of repetitive lifting of her patient. Respondent alleged that Petitioner did not provide proper notice of accident because she complained of symptoms dating back to 2009, or possibly even 2010, so therefore did not provide proper notice of accident. Respondent further alleged that the reasonable employee would have known she was injured and should have reported the injury to her employer at that time. The manifestation date of a repetitive trauma injury is not necessarily the date on which the employee notices the injury. *Durand v. Industrial Comm'n*, 224 Ill. App. 2d 53, 68 (2006). Thus, it is reasonable that the manifestation date of her repetitive lifting injury was when she first sought medical care and a medical professional causally linked her injuries to her work-related activities.

The medical records of Dr. Vargas indicate that although Petitioner began experiencing symptoms three years prior, the pain only became so intense in the last few months as to necessitate medical intervention. (Px5, 7/25/12 note and Px4 8/15/12 note) Respondent's argument that Petitioner's accident manifested in 2009 or 2010 is flawed. Although Petitioner "knew" her pain was related to working with a heavy patient, there was no doctor confirmation and she was able to continue on with her full-duty work until June, 2012, when she sought medical care. At that time, she put Respondent on notice. The Commission finds that Petitioner met her burden that she sustained a work-related accident that manifested in June, 2012, and that the Respondent was given proper notice. Additionally, Petitioner filed her Application for Adjustment of Claim prior to the expiration of the statute of limitations.

Additionally, the Commission finds that Petitioner's current condition of ill-being is causally related to her accident. Petitioner introduced MRIs of her cervical and lumbar spine into evidence. Even Respondent's expert agreed that Petitioner's imaging studies showed evidence of a disk bulge, as well as foraminal narrowing in both the cervical and lumbar spine. Respondent's expert's recommended treatment was for epidural steroid injections. (Rx1) Petitioner's treating

physicians had also recommended treatment in the form of epidural steroid injections. (Px4 8/15/12 note) To establish causation under the Act, Petitioner need not prove that her employment was the sole causative factor, or even that it was the principal causative factor, but only that it was *a* causative factor in her condition of ill-being. *Tolbert v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130523WC, ¶54. Petitioner gave consistent and credible medical histories regarding the repetitive lifting of a very heavy patient. Her testimony was consistent with her medical histories that day in and day out she was lifting and transferring a 250-300 pound patient multiple times per day.

Finally, the Commission finds that the Petitioner is entitled to reasonable and necessary medical treatment related to her injury and subject to the fee schedule. Further, as Petitioner's injury occurred after September 1, 2011, §8.1b of the Workers' Compensation Act is applicable. The Commission finds that Petitioner is entitled to 5% loss of a person as a whole. Taking the factors of §8.1b of the Workers' Compensation Act into consideration, this award is based on the following:

- Petitioner's reported level of impairment is N/A – no impairment rating was submitted. The Commission gives this factor no weight.
- Petitioner is a personal assistant/home health aide, and the Commission gives this factor some weight towards an increased permanency.
- Petitioner was 48 years old at the time of injury, and the Commission gives this factor some weight towards an increased permanency.
- Petitioner's future earning capacity appears to remain unchanged. Petitioner continued to work full duty without restrictions, reduced hours, assistance, etc., and the Commission gives this factor some weight towards an increased permanency.
- Although Petitioner reported pain of 10/10 at times, combined with her diagnostic imaging studies and proposed treatment, Petitioner's disability appears treatable, and the Commission gives this factor some weight towards an increased permanency.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $475.77 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 5% loss of use of person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $16,491.62 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 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:

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 052318
49

JUL 16 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GAINER, TRACIE
Employee/Petitioner

Case# **12WC021754**

ILLINOIS DEPT OF HUMAN SERVICES
Employer/Respondent

18IWCC0438

On 8/11/2016, 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:

4977 LAW OFFICES OF JASON S SHETH
6900 MAIN ST
SUITE 157
DOWNERS GROVE, IL 60516

5604 ASSISTANT ATTORNEY GENERAL
DAVID CHRISTENSEN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

AUG 11 2016

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

18IWCC0438

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tracie Gainer
Employee/Petitioner

v.

Illinois Department of Human Services
Employer/Respondent

Case # 12 WC 21754

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Brian Cronin, Arbitrator of the Commission, in the city of **Geneva**, on **October 14, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 14, 2012**, Respondent **was** operating under and subject to the provisions of the Act.

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

On this date, Petitioner **did 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 **$41,233.40**; the average weekly wage was **$792.95**.

On the date of accident, Petitioner was **48** years of age, **married** with **1** dependent child.

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

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

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

ORDER

Compensation is hereby denied.

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

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

Signature of Arbitrator — **8/10/2016** Date

AUG 11 2016

STATE OF ILLINOIS)
)
COUNTY OF DuPage)

18IWCC0438

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tracie Gainer
Petitioner/Employee

Case # 12 WC 21754

v.

DuPage: Arbitrator Brian Cronin

Illinois Department of Human Services
Respondent/Employer

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

This action was pursued under the Illinois Workers' Compensation Act (the "Act") by the Petitioner-Employee Tracie Gainer and sought relief from the Respondent-Employer, the State of Illinois, Illinois Department of Human Services (D.H.S.).

On October 14, 2015, a hearing was held before Arbitrator Brian Cronin, in Geneva, Illinois. Petitioner was permitted to re-take the stand to provide additional testimony regarding the issue of "notice" after which proofs were closed. The Illinois Attorney General represented DHS in the arbitration proceedings. The Petitioner was represented by Attorney Jay Sheth.

Tracie Gainer (the "Petitioner") was forty-eight years old [Ax1] on June 14, 2012, the alleged date of injury. At that time the Petitioner was married with one dependent child [Ax1].

A. Summary of Petitioner's Testimony at Trial

Petitioner testified that she has worked as a personal assistant (P.A.) for 17 years. She worked as a PA for four years in Pennsylvania and for 13 years in Illinois. She received state training in both states.

Petitioner testified that on July 1, 2009, she began taking care of Mr. Luigi Amella. She has continued to take care of him since that date. Petitioner met Mr. Amella through the Department of Human Services. Mr. Amella suffered a traumatic brain injury and is significantly disabled. He cannot walk, has limited motor control and cannot feed, bathe or otherwise care for himself. He is unable to lift his arms and legs completely. His disability has worsened over time. He weighs approximately 268 pounds or more so now. She then testified that he weighs in the range of 275-300 pounds. His weight has not changed significantly during the relevant period.

Petitioner testified that Mr. Amella has required care 24 hours a day, 7 days a week. When she began providing services for Mr. Amella, he resided with his wife. Petitioner approximated that during that time, she worked from 6:30 a.m. – 6:30 p.m. An additional P.A., Ashley White, the Petitioner's daughter, also provided P.A. services to Mr. Amella.

Mr. Amella later divorced and moved into a townhouse. Petitioner testified that during that time, she provided care to Mr. Amella 24 hours a day, 7 days a week.

In approximately May of 2012, Mr. Amella was potentially going to be placed in a facility where he would be provided care by another entity. Petitioner testified that she offered to let Mr. Amella move in with her instead. With the approval of Mr. Amella's family, Mr. Amella moved into Petitioner's home. Petitioner testified that she preferred this option to having Mr. Amella cared for by others in a facility.

After Mr. Amella moved in with Petitioner, she continued to provide care to him 24 hours a day and 7 days a week. It should be noted that on July 27, 2012, just two months later, her physical therapist notes that "she tended to talk about how caring for the patient in her home was ruining her health and how she cannot get him to allow his being moved to a facility." [Px5]

Petitioner testified that her duties included rolling, pulling, lifting, transferring, toileting, bathing, and feeding Mr. Amella, as well as doing his laundry and administering his medicine.

Petitioner had to transfer Mr. Amella between chairs. In the mornings, she would transfer him from the bed to the wheelchair, change his sheets, then transfer him back into bed, then out of bed and into the wheelchair and then out of the wheelchair and into the shower to bathe him, then back into the wheelchair, then to a chair in the kitchen to feed him, then back to the wheelchair, then to the toilet, then back to the wheelchair, then to another chair.

Petitioner testified that she did all this activity without the help of a Hoyer lift, which she requested many times from the State.

Petitioner further testified that this type of transferring continued throughout the day, including, when necessary, for travel. She occasionally has to take him to the dentist. Sometimes he wants to go to the grocery store. This involves rolling him in his wheelchair down the ramp and lifting him out of the chair and placing him in the vehicle. When she reaches the destination, she must lift him out of the vehicle and into the wheelchair. If Mr. Amella wants to go to the park, she takes him to the park.

Petitioner testified that she lifts and transfers Mr. Amella approximately 9 times in a morning. She testified that she lifts and physically works with Mr. Amella 60-70 times on a good day and 80-85 times on a bad day. She also testified that she frequently has to re-position Mr. Amella in his chairs when he slumps. It was unclear whether these re-positioning acts were part of or in addition to the number of lifts she testified she performs a day.

Petitioner testified that she and Luigi Amella have to work as a team because it is all manual and no one wants to get injured. She testified that it takes all of her upper body strength, back and legs to lift him. Mr. Amella is very large and heavy. She then testified that it is

entirely on her and he is dead weight. She testified that he has many bowel movements in the course of a day.

Petitioner testified to the approximate amount of time she spends on each activity for Mr. Amella every day. She testified that it takes approximately 7 minutes a day to get Mr. Amella out of bed, 2½ -3 hours a day to bathe him, 14+ hours a day for Mr. Amella to use the bathroom, 4½ hours each day to feed him 3 meals, 3 hours each day to prepare meals, 4 hours a day to do laundry and 2 hours a month to pay bills and manage finances. She testified there are other tasks she performs, such as grooming and changing the dressing on his toe, for which she is unable to estimate the time.

Petitioner testified that she was aware that D.H.S. limited the number of hours that she can submit for payment for caring for Mr. Amella. She was originally allowed to perform 357 hours of work a month, approximately 11.5 hours a day. She testified that in October of 2010, the hours allowed were reduced to 230 hours a month, approximately 7.5 hours a day. Petitioner denied that she was told the hours that she submitted were too many. (Rx.2) Petitioner testified that in December 2010, she appealed a decision that dealt with a reduction in the number of hours she submitted to D.H.S.

Petitioner testified that prior to her first visit to Dr. Vargas, she was aware that she was having neck and back problems. She testified that her back and neck symptoms were getting worse and worse. Petitioner testified that probably 2 years before she saw Dr. Vargas, she knew that lifting Luigi Amella was the cause of her injuries.

Petitioner sought medical treatment with Dr. Vargas in June 2012. She did not seek medical treatment prior to that date.

Petitioner testified that she is alleging that she sustained an accident on June 14, 2012.

Petitioner testified that she has not taken any time off of work.

She testified that she continues to care for Mr. Amella.

On redirect examination, Petitioner testified that Ashley did not assist her, but was pulled in when Petitioner needed her.

The Arbitrator allowed the parties to take further testimony from Tracie Gainer after Respondent placed the issue of notice in dispute.

Petitioner testified that she previously testified that she first saw Dr. Vargas on June 14, 2012. She testified that prior to that date, no doctor said that her condition was related to her work. Petitioner admitted that before that date, she thought her symptoms were related to her work. She suspected that her pain was attributable to her work. She testified that she is not a doctor and did not know that that was the case. Petitioner further testified that the date of June 12, 2014 was not only the first time a doctor told her that her symptoms were related to her work, but it was the first date that she treated for this condition. Petitioner testified that her condition has gotten worse.

B. Medical Treatment and Testimony

On June 14, 2012, the Petitioner first sought treatment at Michigan Avenue Medical Associates, (Michigan Ave). She was first seen by Dr. Olefsky who diagnosed her with a lumbar strain with radiculopathy. She was instructed to undergo physical therapy. She was also referred for an MRI and instructed to stay off work. [Px4]

On July 21, 2012, the requested MRIs of the lumbar and cervical spine were performed. The reports indicated L1-S1 diffuse disc bulges, as well as, a C5-6 disc budge with stenosis. [Px4].

On July 23, 2012, Petitioner followed up at Michigan Ave and was seen by Dr. Riera. She indicated she had 7-8/10 back pain, which radiated to her right leg. She was diagnosed with lumbar radiculopathy. She was instructed to undergo physical therapy and was given pain medications. She was released with no restrictions. [Px4].

From July 25, 2012 to August 8, 2012, she underwent five sessions of physical therapy with limited improvement. On July 25, 2012, her physical therapist noted that she reported having had pain for three years. This indicates that her pain began in July 2009. On July 27, 2012, her physical therapist noted that "An antalgic gait pattern was observed, but increased RLE stance phase was observed during retro walking on the treadmill." On July 30, 2012, her physical therapist noted that "Although she is demonstrating decreased tolerance for certain PT activities, a slightly improved gait pattern (less limping on the R and slightly increased step length) was observed during treadmill activities." [Px5].

On August 13, 2012, Petitioner returned to Michigan Ave and was seen again by Dr. Riera. She complained of neck and low back pain at an eight out of ten level. She was instructed to continue physical therapy and was referred to Dr. Vargas. [Px4].

On August 15, 2012, Petitioner first received treatment from Dr. Vargas. She complained of neck pain between a four and a seven out of ten and of back pain between a six and a nine out of ten. She was diagnosed with (1) cervical & lumbosacral spondylosis (a degenerative osteoarthritis), (2) discogenic cervical and lumber radiculopathy, (3) lumbo sacral facet arthropathy (a form of arthritis) and (4) spinal stenosis (narrowing of the spine). Dr. Vargas recommended that she continue physical therapy and undergo injections. [Px4]

From August 17, 2012 to August 25, 2012, she underwent an additional five physical therapy sessions. At her August 25, 2012 session, it is again noted that she had pain for three years, again indicating her pain began in July of 2009. [Px5].

On January 30, 2013, nearly five months after last examining the Petitioner, at the request of Petitioner's counsel, [Vargas P.24, Lines 6-8], Dr. Vargas issued an addendum to his August 15, 2012, office visit notes to indicate that he believed that Petitioner's condition was the result of a work-related repetitive injury. [Px4].

On June 14, 2014, Petitioner had her second visit with Dr. Vargas. Her complaints of neck and back pain continued. She stated her back pain was a six to nine out of ten and her neck pain was a four to seven out of ten. Dr. Vargas' diagnosis remained unchanged. Dr. Vargas states that his findings are clearly suggestive of lumbosacral disc disease and cervical disc disease. Dr. Vargas again recommended epidural steroid injections and also, possibly, intra-articular facet joint injections. He does not at any time indicate fusion surgery would be recommended. [Px7].

B1. Deposition of Dr. Vargas

The deposition of Dr. Vargas was taken on October 7, 2013.

Dr. Vargas testified that he observed the Petitioner in his examination room walking with a limp and having difficulty getting onto the examining table. [Vargas P. 13, Lns. 11-16]. Dr. Vargas opined that Petitioner's neck and back complaints were a result of the repetitive lifting injury she sustained by working with Mr. Amella. [Vargas P.23-24, Lns.18 – 1]. Dr. Vargas testified that the treatment the Petitioner underwent was reasonable and necessary. [Vargas P. 33, Lns. 4-10].

Dr. Vargas testified to the following:

Q: Doctor, presently with regard to the spinal injuries, both in the neck and the low back, could you provide an opinion as to whether or not you believe these injuries are permanent?

A: It is very difficult for me to determine that unless I see the patient again to see whether - - I mean, I can't - - there is no comment. I cannot comment on that.

Q: Okay. But just to ask you to follow up on that, with regard to the MRI and the spinal injuries, do those injuries tend to be permanent?

A: Once you have foraminal stenosis, or you have basically a pathology that narrows the canal, they are permanent unless you have a spinal fusion.

Q: But right now you don't know whether that would be reasonable treatment for her?

A: I don't know. As I said, I need to see the patient again. [Vargas P. 34-35]

Dr. Vargas' subsequent treatment notes, from June 14, 2014, do not contain a recommendation of fusion surgery. [Px7]. Dr. Vargas testified that he did not review the actual MRI images [Vargas P. 15, Lns. 19-22]. Dr. Vargas testified: "We just have to believe patients by default. We have to rely on patient's history." [Vargas P. 47, Lns. 13-15]. Dr. Vargas testified that all he was told regarding the Petitioner's job activities was "the lifting and pulling a 250–pound heavy patient she has been taking care of for the past three years..." [Vargas P. 41-42, Lns. 18-11]. Petitioner did not tell him how many days a week she worked with Mr. Amella [Vargas P. 42, Lns. 12-15] nor how often she lifted Mr. Amella [Vargas P. 43, Lns. 13-18], nor did she explain what she meant by "lifting" [Vargas P. 43, Lns. 19-24.], She did not explain how she transferred Mr. Amella, she did not tell him whether she had assistive equipment, nor did he review her job description [Vargas P. 44, Lns. 1-18]. Dr. Vargas testified that he opined that Petitioners condition was caused by her activities with Mr. Amella because "...somebody that is

not involved in lifting a 250-pound mass, on a regular basis, would not have any symptoms. Otherwise, everybody at the age of 48 would have symptoms just for being 48. So, naturally, people don't have symptoms unless there is something that prompts the symptoms." [Vargas P. 46, Lns. 18-24]. He does not address the physical therapy notes showing that, pursuant to the Petitioner, her pain complaints started prior to her providing care to Mr. Amella. [Px5 & Vargas Dep.]

B2. Section 12 Examination by Dr. Phillips

On April 19, 2013, the Petitioner was examined by Dr. Phillips. Petitioner related a gradual onset of neck and back symptoms which in June of 2012 prompted her to seek medical attention. [Phillips P.2 para. 3]. She complained of neck and back pain radiating into her right leg and arm. She related that her pain was a ten out of ten.

Dr. Phillips reviewed the actual MRI images and described same as a poor quality image which showed only a L5-S1 disc bulge and possible foraminal narrowing at L4-S1 and C3-6. [Phillips P. 3, para. 2-3].

Following his examination of Petitioner, Dr. Phillips observed Tracie Gainer assisting an individual into a vehicle. He noted that she moved freely and that she bent over and lifted a wheelchair into the vehicle without any apparent pain. These observations were inconsistent with observations during his office examination. [Phillips P. 3, Para 4] Dr. Phillips stated that these observed actions suggest that Petitioner sustained no injury as allegedly related to her work activities. [Phillips P. 3, para. 7] Dr. Phillips opined that Petitioner's underlying mild degenerative changes are responsible for her current symptoms. Dr. Phillips states: "If indeed she does have radicular complaints, these are reflective of the natural history of her underlying condition." [Phillips P. 3, para. 6]. Dr. Phillips opined that Petitioner's symptoms

are not the result of her work, [Phillips P. 3, para. 5], and that her symptoms and the related treatment are a result of her underlying condition. [Phillips Finding #2 and #3]

II. CONCLUSIONS OF LAW

C. The Injury Did Not Arise Out Of and In The Course of Employment.

In this case, the Arbitrator finds that the repetitive trauma injury claimed to have arisen out of repeatedly lifting a patient did not arise out of or in the course of employment, as the pain began prior to the commencement of the service and when the bulk of the provided work occurred outside of the employee's work hours.

For an injury to be considered to have arisen out of the employment the employee must be performing some task in the furtherance of the employer's business or incidental thereto. The mere fact that the worker is at the place of injury because of the employment will not suffice. Quarant v. Industrial Commission, 38 Ill.2d 490, 231 N.E.2d 397 (1967).

In Martin v. Kralis Poultry Co., 12 Ill. App. 3d 453, 297 N.E.2d 610 (1973), the employee was injured when she slipped and fell in entranceway leading into employer's plant after her working hours. In that case, the employee clocked out and left employer's plant two hours before she sustained her injury, then choose to return at the personal request of her husband, who was employed as a superintendent. The Court held that the injury to employee did not arise out of and in course of her employment and was not covered by Workers' Compensation Act. Martin v. Kralis Poultry Co., 12 Ill. App. 3d 453, 297 N.E.2d 610 (1973). The Court stated: "two hours after the normal work day had ended, the evidence supports the conclusion that there was no lawful direction by the employer that she perform an unusual task

and no benefit that her presence on the employer's premises could render the company." Martin v. Kralis Poultry Co., 12 Ill. App. 3d 453, 462, 297 N.E.2d 610, 616-17 (1973).

In this case, Petitioner was directed to stop providing care for Mr. Amella after a certain number of hours and then chose, on her own time, to provide services to Mr. Amella as a voluntary act. Petitioner testified that she knew she was to provide care for Mr. Amella for a limited number of hours. Her "shifts" were originally 11.5 hours a day or 357 hours a month and were reduced to 7.5 hours a day or 230 hours a month. [Pet Testimony] Instead, Petitioner chose to provide services to Mr. Amella 24 hours a day, 7 days a week. By her own testimony, just performing part of the tasks she provided, she worked 28 hours a day, although doing laundry could be concurrent with other tasks. If her injuries were caused by her activities with Mr. Amella at all, her repetitive back and neck injuries were caused by her voluntarily choosing to perform acts when she was no longer acting on the behalf or request of D.H.S. and well outside her allowed hours. D.H.S. repeatedly instructed her to work only the hours she was allowed and her refusal to do so and her voluntary acts performed after or before her working hours are not the responsibly of D.H.S. D.H.S. does not have the ability to, or authority to, instruct Petitioner on what she may or may not do on her own time. Her choice to perform extra voluntary acts for Mr. Amella, including moving him into her home, was her decision and D.H.S. is not responsible for the result of actions she choose to pursue on her own time. While Mr. Amella received a benefit from Petitioner's voluntary actions, D.H.S. received no benefit from Petitioner's voluntary actions.

Further, the Petitioner testified that she had the opportunity in May of 2012 to cease providing services for Mr. Amella. The option was available to have Mr. Amella placed into a facility, at which time she would no longer have been required to care for him. Mr. Amella

could have been facilitated and Petitioner could have taken on another client. However, Petitioner chose to move Mr. Amella into her home and chose to voluntarily provide substantial additional care that was not authorized, requested or for the benefit of D.H.S. It should be noted that on July 27, 2012, just two months after this option became available, her physical therapist notes that "she tended to talk about how caring for the patient in her home was ruining her health and how she cannot get him to allow his being moved to a facility." [Px5].

Based upon the above, this Arbitrator finds that the injury alleged did not occur or arise out of or in the course of employment. Petitioner was clearly acting voluntarily and outside the scope of her employment. She was not authorized to, or requested to, perform these additional acts by Respondent.

D&E. The Manifestation Date Occurred In Late 2009 or Early 2010 and Timely Notice Of the Accident Was Not Provided to Respondent.

The test for the determination of the date of accident in a repetitive injury cases is best set forth in Durand v. Indus. Comm'n, 224 Ill. 2d 53, 862 N.E.2d 918 (2006). Therein, the Court stated that "an employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. … Setting this so-called manifestation date is a fact determination for the Commission." Durand v. Indus. Comm'n, 224 Ill. 2d 53, 65, 862 N.E.2d 918, 924-25 (2006). The Durand Court stated: "courts … have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities." Durand v. Indus. Comm'n, 224 Ill. 2d 53, 72, 862 N.E.2d 918, 929 (2006) However, the Court made clear that these factors are solely "… relevant in determining objectively when a reasonable person would have plainly

recognized the injury and its relation to work." Durand v. Indus. Comm'n, 224 Ill. 2d 53, 72, 862 N.E.2d 918, 929 (2006).

Durand makes clear that the ultimate question is when a reasonable person would have plainly recognized the injury and its relation to work. Petitioner made this clear during cross-examination:

Q: Prior to seeing Dr. Vargas, you had a suspicion that it was caused by lifting Mr. Amella?

A: No, I didn't have a suspicion. I knew it was from that because prior to that, I didn't have any injuries.

*****

Q: No. When did you first - - when did you first remember or recall feeling neck or back pain?

A: I can't recall. I really - - honestly. It's just - - it just gradually got worse and worse.

Q: Was it a year prior to seeing Dr. Vargas, two years prior to seeing Dr. Vargas?

A: Well, yes.

Q: How many years before seeing Dr. Vargas was it?

A: That I began to feel pain what? Pain in general?

Q: Neck and back pain.

A: Prior to seeing Dr. Vargas - - probably two years before I even saw Dr. Vargas.

Q: And at that same time, you knew it was because you were working with Mr. Amella, correct?

A: Absolutely. I didn't know - - I'm not a doctor. I'm an aide. I don't know the science of medicine. What I do know is prior to working with Luigi and lifting him and pulling him,

everything that entails in that job and that line of work, what I do know is I didn't have a back problem or neck problem or any of that, and what I do know at certainty is that over the course of taking care of Luigi, the pain got to the point where it was no longer just uncomfortable. It became acute. It became so acute to the point where I had to take care of myself and I had to seek a physician. (Tr. 74, 75)

Then later in the hearing, Petitioner testified to the following:

Q: With regard to whatever testimony you had in the past earlier today about your noticing the symptoms and believing them to be work related, could you explain to the Arbitrator what your thoughts were at that time about whether you knew they were work related or certain they were work related. Expand on that.

A: I didn't know with any certainty. I'm not a doctor. I didn't know for sure with anything. I just simply suspected that that is where my pain is coming from being job related. You know, it was just my own - - my own personal that I suspected that it could only be from that, but no one told me. I'm not a doctor so I don't know for medical certainty. I suspected that.

Q: Just to confirm, too, not only was that the first time that a doctor had told you that was the case, but that was the first time you also actually received medical treatment for those symptoms.

A. Absolutely.

Q: Okay. And it was an ongoing thing that built up to a certain point?

A: Yeah. Built up to the point where I needed to seek a physician. (Tr. 100-101)

The Arbitrator finds Petitioner's earlier testimony regarding what she knew and when she she knew it (Tr. 74, 75) to be more credible than her later testimony. (Tr. 100-101)

She testified earlier that she didn't have a suspicion, she knew that her injuries were caused by lifting Mr. Amella, and that it was probably 2 years before she saw Dr. Vargas. (Tr. 74, 75) She was not equivocal.

Durand states: "an employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person." Durand v. Indus. Comm'n, 224 Ill. 2d 53, 65, 862 N.E.2d 918, 924-25 (2006). Petitioner has pointed to a date on which she knew of her injury and knew it was related to her work. She testified that this date was approximately in June of 2010. Therefore Petitioner's was required by Section 6(c) of the Act to inform D.H.S. within 45 days thereof. As Petitioner did not inform D.H.S. until June of 2012, she has failed to provide proper notice.

Respondent has been severely prejudiced by Petitioner's failure to inform them of the injury she knew she was suffering. As set forth in Ristow v. Indus. Comm'n, 39 Ill. 2d 410, 235 N.E.2d 617 (1968) "Section 6(c) explicitly provides that no proceeding can be maintained unless the employer has been given notice of accident within the statutory period. As in other statutes of limitation, there is a conclusive presumption that the employer has been prejudiced by the failure to notify." Id. at 414 (Emphasis added). Had Petitioner informed D.H.S. in 2010, action could have been taken to avoid her claimed repetitive trauma injury, such as authorizing more hours for Ashley White, or placing Mr. Amella in a facility where he would be cared for by another entity, an option which Petitioner herself said she was aware of and voluntarily chose to avoid by moving Mr. Amella into her home instead. Petitioner could have then sought another client.

However, Petitioner chose not to make D.H.S. aware of her alleged work injury, which she testified she knew of at that time, and chose to move Mr. Amella into her home and chose to voluntarily provide substantial care outside of the hours allowed by D.H.S.

Based upon the above, this Arbitrator finds that the manifestation date occurred in June 2010, at which time Petitioner was aware of her injury and knew that it was related to work. Therefore, Petitioner failed to prove that she provided timely notice of the accident to Respondent; Respondent was prejudiced by such failure.

F. The Petitioner's Current Condition of Ill-being Is Not Causally Related to the Injury

Petitioner presented the opinions of Dr. Vargas. At his first examination of the Petitioner, Dr. Vargas diagnosed the Petitioner with several degenerative conditions and associated radiating pain, (1) cervical & lumbosacral spondylosis (a degenerative osteoarthritis), (2) discogenic cervical and lumber radiculopathy, (3) lumbo sacral facet arthropathy (a form of arthritis) and (4) spinal stenosis (narrowing of the spine). It was not until nearly five months after the examination, and at the request of Petitioner's counsel [Vargas P.24, Lns. 6-8] that Dr. Vargas indicated, in an addendum, that he believed that Petitioner's condition was the result of a work-related repetitive injury. Dr. Vargas repeated this opinion in his deposition [Vargas P.23-24 Lns.18 – 1]. However, Dr. Vargas testified that he just had to believe the patient by default [Vargas P. 47, Lns. 13-15] and that all he was told about her job duties was that she was "lifting and pulling a 250–pound heavy patient she has been taking care of for the past three years …" [Vargas P. 41-42, Lns. 18-11]. Dr. Vargas testifed that he was not told:

> How many days a week Petitioner worked for Mr. Amella [Vargas P. 42, Lns. 12-15],
> How often Petitioner lifted Mr. Amella [Vargas P. 43, Lns. 13-18],
> What Petitioner meant by "lifting" [Vargas P. 43, Lns. 19-24.],
> How Petitioner transferred Mr. Amella, [Vargas P. 44, Lns. 1-18],

Whether Petitioner had assistive equipment, [Vargas P. 44, Lns. 1-18],
He did not review her job description [Vargas P. 44, Lns. 1-18],
He did not review the actual MRI images [Vargas P. 15, Lns. 19-22].

Dr. Vargas' preliminary hypothesis with regard to the cause of Petitioner's injuries related to the pulling and lifting a very heavy patient for the past three years and the repetitive nature of such activities. In response to a hypothetical of Petitioner's duties for the past 3 years, (working with a 250-300 pound wheelchair-bound man with all the duties associated with that such as getting him in and out of bed, wheelchair, bathroom assistance, showering, dining, setting – which for herself required kneeling, squatting, and lifting, etc. 50-60 times per day without personal assistance or machinery), that those activities could have contributed to or caused the pathologies previously discussed. (Vargas P. 25-28). He explained the basis for this opinion is the physical and mechanical forces involved and the axial pain on the spine that would result in radiculopathy. He opined that these injuries can develop as a result of lifting or pulling a heavy person or mass. When one is involved in lifting a heavy load in a non-adequate fashion, like pulling, tugging, et cetera, one can actually produce some internal disruption of the disk and the structure within the disc. It will result in a discogenic breakdown. (Vargas P. 29-30)

Dr. Vargas testified that his opinion was that "… somebody that is not involved in lifting a 250-pound mass, on a regular basis, would not have any symptoms. Otherwise, everybody at the age of 48 would have symptoms just for being 48. So, naturally, people don't have symptoms unless there is something that prompts the symptoms." [Vargas P. 46, Lns. 18-24].

Dr. Vargas testified he could not determine whether the Petitioner's condition was permanent. [Vargas Ps. 34-35, Lns. 20-3]. Dr. Vargas testified that he did not know if fusion surgery would be reasonable and stated he would need to examine her again. [Vargas P.35, Lns. 7-14] After subsequent examination he still did not recommend a fusion surgery. [Px7].

Respondent presented the medical opinions of Dr. Phillips, who conducted a Section 12 examination of Petitioner on April 19, 2013. He took a history that included the following:

> Today, Ms. Gainer is a 48-year-old woman who describes doing lifting and transfer of patients during her job activities. She describes she had gradual onset of back and neck symptoms that in June 2012 reached the point of getting "out of control." She, today, denies any specific injury in June 2012 as provoking her symptoms and feels as if symptoms have been developing over months with her work activity. She informs me fusion surgery is being recommended.

Dr. Phillips examined Petitioner and diagnosed her with cervical and lumbosacral spondylosis (a degenerative osteoarthritis). [Phillips Finding #1] Dr. Phillips found, *inter alia*, that Petitioner completed a "nonanatomic" pain diagram, that she has at least 3 Waddell signs - positive with marked superficial tenderness to even the lightest palpation, that she has regional nonanatomic weakness, as well as overreaction, that Spurling's and Lhermitte's cause neck pain only, and that she has very diffuse symptoms throughout her neck and back as well as in her right upper and lower extremities. Dr. Phillips reviewed the actual MRI images, which showed only a L5-S1 disc bulge and possible foraminal narrowing at L4-S1 and C3-6. [Phillips P. 3, paras 2-3]. Dr. Phillips opined that it is Petitioner's underlying cervical and lumbar spondylosis that is symptomatic and that she did not sustain any acute injury to her cervical and lumbar spine and that her condition and treatment is reflective of the underlying condition and not related to her claim of repetitive bending. He opined that Petitioner's underlying mild degenerative changes are responsible for her current symptoms and that "[i]f indeed she does have radicular complaints, these are reflective of the natural history of her underlying condition." [Phillips P. 3, para. 6, Phillips Finding #2 and #3].

Both providers had the opportunity to observe the Petitioner. Dr. Vargas was able to observe the Petitioner while in his examination room and testified that Petitioner walked with a

limp and had difficulty getting onto the examining table. [Vargas P. 13, Lns. 12-16]. Dr. Phillips, however, also observed the Petitioner when she was leaving the examination, and stated that he saw her assisting an individual into a vehicle and moving freely as she bent over and lifted a wheelchair into the vehicle without any apparent pain. These observations were inconsistent with his observations during his office examination of Petitioner. [Phillips P. 3, para. 4] These observations undermine the Petitioner's credibility and the credibility of her subjective complaints.

Both medical providers diagnosed the Petitioner with degenerative osteoarthritis. Dr. Phillips opined that Petitioner's symptoms are the result of these degenerative conditions. Dr. Vargas opined: "... somebody that is not involved in lifting a 250-pound mass, on a regular basis, would not have any symptoms. Otherwise, everybody at the age of 48 would have symptoms just for being 48. So, naturally, people don't have symptoms unless there is something that prompts the symptoms." [Vargas P. 46, Lns. 18-24]

Dr. Vargas' opinion that a forty-eight year old would not have back pain without some cause and that therefore that cause must be the claimed repetitive lifting is based upon a correlative relationship not a causative relationship. Simply because something must have a cause does not mean something else which occurred at a similar time is that cause.

The Arbitrator finds the opinions of Dr. Phillips to be more credible than those of Dr. Vargas.

The Arbitrator made his own observations during the hearing. When Petitioner was first called to the witness stand, she walked up to the witness stand slowly with what appeared to be an antalgic gait and was hunched over as she walked. However, when Petitioner concluded her

testimony, left the witness stand and exited the hearing room, she walked in an upright position and in what appeared to be a pain-free manner.

The Arbitrator finds Petitioner's estimates of the approximate time she spends on each daily activity for Mr. Amella to be excessive.

Petitioner testified that she has to "stand up" Mr. Amella and that it takes all of the strength in her arms and legs to lift him. However, Petitioner also testified that she and Luigi Amella have to work as a team because it is all manual and no one wants to get injured. The Arbitrator makes the reasonable inference, given Petitioner's testimony, her stature and Mr. Amella's size, that he is able to stand up primarily on his own, but with some assistance from Petitioner.

Petitioner declined epidural steroid injections as recommended by Dr. Vargas, purportedly because she would have had to take off work to receive them. She declined such treatment despite her testimony that she would "pull in" Ashley White whenever she needed her. Ashley White is Petitioner's daughter and is also a Personal Assistant who has provided P.A. services to Mr. Amella.

Petitioner has lost no time from work as a result of these claimed accidental injuries.

Based on the above, this Arbitrator finds that the Petitioner has failed to meet the burden of proof and therefore finds that her current condition of ill-being is not causally related to a June 12, 2012 accident.

The Arbitrator denies compensation, based on his findings of fact and conclusions of law with regard to the issues of accident, notice and causation. All other issues have been rendered moot.

Brian Cronin, Arbitrator

8-10-2016

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Kauling,

Petitioner,

vs. NO: 15WC 38690

State of Illinois/Centralia Correctional Center,

Respondent.

18IWCC0439

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 12, 2017 is hereby affirmed and adopted.

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

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

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: JUL 17 2018
SJM/sj
o-6/7/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KAULING, BRIAN
Employee/Petitioner

Case# **15WC038690**

ST OF IL/CENTRALIA CORR CENTER
Employer/Respondent

18IWCC0439

On 12/12/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

DEC 12 2017

BERNARD A. HASELER, 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

BRIAN KAULING
Employee/Petitioner

v.

STATE OF IL / CENTRALIA CORR. CENTER
Employer/Respondent

Case # 15 WC 38690

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **June 14, 2017**. By stipulation, the parties agree:

On the date of accident, **November 9, 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 **$58,032.00**, and the average weekly wage was **$1,116.00**.

At the time of injury, Petitioner was **36** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$18,919.62** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$18,919.62**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$669.60 per week** for **87.5 weeks**, because the injuries sustained caused the **17.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **September 15, 2016** through **June 14, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

December 6, 2017
Date

DEC 12 2017

STATEMENT OF FACTS and CONCLUSIONS OF LAW

Petitioner, a 7 year employee, worked for Respondent at Centralia Correctional Center as a correctional officer (CO). He testified he was injured at work on 11/9/15 when he was involved in a training simulation and, while playing the role of an inmate, was forced to the ground by another CO.

On 11/9/15, Petitioner presented to St. Elizabeth's Urgent Care with complaints of 7 out of 10 neck pain after a co-worker fell on him during cell extraction training. He denied numbness and tingling. A cervical CT scan was obtained which showed mild degenerative changes at C1/2 and C7 without fracture, and nonspecific mildly prominent lymph nodes throughout the neck. The diagnosis was a cervical strain, hydrocodone and tramadol were prescribed, and Petitioner was advised to follow up with his primary care provider if the pain didn't resolve in a week. (Px3).

The Petitioner followed up at Clinton County Rural Health on 11/11/15, reporting a consistent history of injury and complaining of neck pain radiating to his upper back with no numbness and tingling. He was diagnosed with a right neck strain, prescribed Flexeril and advised to take ibuprofen. The report also states: "may call chiropractor for appt." (Px4).

Petitioner underwent chiropractic treatment with Dr. Hippard from 11/17/15 to 12/17/15. Petitioner had complaints of right-sided neck and trapezius area pain, as well as headaches, and underwent chiropractic manipulation as well as soft tissue massage with biofreeze. The diagnoses were cervical ligament sprains, cervical disc degeneration, segmental and somatic dysfunction of cervical region, and segmental and somatic dysfunction of thoracic region. The Petitioner denied any similar prior problems. By 12/17/15, Petitioner had noted some improvement, but no resolution of his symptoms. The Arbitrator did not note a specific discharge from care. (Px5).

Petitioner followed up at Clinton County Rural Health on 1/28/16 noting he still had neck pain and had occipital headaches, and he wanted to discuss an MRI. The assessment was cervicalgia, an x-ray and Medrol dosepak were prescribed, and Petitioner was advised to keep his appointment with "specialist." The cervical x-ray that day showed a loss of lordosis but no fractures. (Px4).

Petitioner next sought treatment on 2/4/16 with Dr. Gornet at the Orthopedic Center of St. Louis. Petitioner had complaints of neck pain to the right side to the base of his neck, into the head and right shoulder. He was continuing to work, but reported worsening with bending, lifting and prolonged sitting and standing. Petitioner also reported right arm weakness and tingling. Examination noted decreased sensation in a C6/7 distribution on the right. (Px6). Dr. Gornet obtained a cervical MRI that day, which Dr. Cizek reported showed a central and right C6/7 disc herniation without nerve root involvement and minimal disc bulges at C3/4 and C4/5 without herniation or stenosis. (Px7).

Following the MRI, Dr. Gornet opined there was a multilevel cervical disc injury, most significantly at C6/7 with "a fairly massive fragment." He recommended a single epidural steroid injection at C6/7, and if that did not result in improvement, he would recommend a single level C6/7 disc replacement. However, he also stated it was possible that other levels would need to be addressed, and recommended a CT myelogram as well. Dr. Gornet opined Petitioner's cervical condition was related to the work injury and allowed the Petitioner to return to full duty. (Px6). The epidural was performed at C6/7 by Dr. Granberg on 2/11/16.

Petitioner returned to Clinton County Rural Health that same day, 2/4/16, for a second opinion, noting Dr. Gornet had advised he would need an epidural and then would need surgery on a "fast track." The nurse practitioner he regularly saw there, Amy Reynolds, noted she did not have the MRI results or the notes of Dr. Gornet, but offered to refer Petitioner to another specialist, which he declined. (Px4).

On 2/25/16, Dr. Gornet noted Petitioner reported improvement in some of his right neck pain with the injection, but an increase in pain on the left side. Dr. Gornet recommended disc replacement surgery at C5/6 and C6/7 and took Petitioner off of work through 4/11/16. (Px6).

The 2/25/16 post-myelogram CT scan reflected a right paracentral C6/7 disc protrusion resulting in ventral cord flattening but no foraminal stenosis, a lobulated left paracentral – foraminal C5/6 disc protrusion resulting in left lateral recess stenosis and mild left foraminal stenosis, and small central protrusions at C3/4 and C4/5 without significant central canal or foraminal stenosis. (Px9).

Dr. Gornet performed the two level disc replacement surgery at C5/6 (with allograft) and C6/7 on 3/16/16. The pre and post-operative diagnoses were cervical radiculopathy. The report notes a large central herniation at C6/7 where it "appeared the patient had ripped his entire annulus off of the superior surface of C7." At C5/6, he noted a central annular tear and small central herniation and "no other problems were noted." (Px6).

Petitioner followed up with Dr. Gornet on 4/11/16 and 5/2/16, reporting that his pain was dramatically improved and that he was very pleased with his progress. He had 5/5 strength in all relevant muscle groups, and Dr. Gornet indicated excellent position of the disc prostheses. Petitioner was continued off work through 6/27/16. (Px6).

A 6/27/16 post-surgical CT study noted anterior decompression and disc replacement at the C5/6 and C6/7 in satisfactory position with no residual central canal or foraminal stenosis at either level, as well as the small central C3/4 protrusion unchanged in appearance with no new central canal or foraminal stenosis. (Px9).

On 6/27/16, Dr. Gornet's report notes that the Petitioner reported increasing neck stiffness over the last several weeks, and the doctor prescribed medication and light physical therapy. X-rays showed excellent position and no evidence of significant lucency of other mechanical issues. Petitioner was cleared to return to unrestricted work duties as of 8/1/16. (Px6).

On 7/20/16, Petitioner presented to Dr. Chabot for a Section 12 examination at the Respondent's request. Petitioner reported mild aching 3/10 neck pain and stiffness with no radicular symptoms and a reduced ability to walk in prolonged fashion without pain increasing. Dr. Chabot noted the Petitioner had cervical full range of motion with no radiating pain and had a negative Spurling's test. He agreed with the treatment to date and also opined that the condition and treatment were work related. He did not believe the Petitioner needed work restrictions. (Rx6).

Petitioner attended physical therapy from 7/5/16 to 8/5/16. On 7/26/16 the Petitioner reported he had no complaints and was ready to return to work, his only concern being endurance for an 8 hour shift. On 8/1/16 he reported ongoing 2/10 to 5/10 neck pain, and his goals had only been partially met. The final report reflects that Petitioner had increasing neck pain since his 8/3/16 return to work with difficulty sleeping. (Px12).

On 9/15/16, Petitioner reported he was doing well despite two or three recent altercations. X-rays showed the C5/6 prosthesis was slightly forward flexed, and that he may have some subtle lucency around the superior C5/6 component. Petitioner had 5/5 strength in all groups, and was allowed to continue to work full duty. (Px6). Petitioner underwent a one year follow up cervical CT scan on 3/16/17 with Dr. Cizek. His report indicates no complications with the disc replacements at C5/6 and C6/7, and facet arthropathy bilaterally at C7/T1 without foraminal stenosis. (Px9). His final follow up with Dr. Gornet that day indicated Petitioner reported he was doing extremely well, and examination indicated normal strength and sensation. He was found to be at maximum medical improvement and was released from care. (Px6).

Petitioner affirmed he had reviewed his medical records and agreed they contained accurate representations of what he told his physicians while under their care. Prior to his surgery he was experiencing neck and radiating pain, and he testified that he felt the surgery was successful. Petitioner testified he was paid for his time off in relation to that surgery. Petitioner testified that his current symptoms were neck pain and limited range of motion. He takes Ibuprofen and rests to treat these symptoms when they arise. As to his day-to-day activities, the Petitioner described pain with activities such as household chores and sleeping. Petitioner also described limiting his participation in hobbies such as golf and martial arts.

On cross examination Petitioner testified he has continued working regular duty since his post-surgical return, and has been able to satisfactorily perform his duties. He has not returned for treatment since he was released from care on 3/16/17, and he is not currently taking any prescriptions. Petitioner confirmed he was not advised to wear any sort of device or brace. There have been no complaints from any supervisors regarding his job performance since he returned to work.

The Respondent submitted a written job description for the Petitioner, most significantly in a physical sense involving the supervision and escorting of prisoners, performing searches and maintaining security. The description also notes requirements including climbing, bending, stooping, running, jumping, walking and standing. (Rx5).

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party has submitted an AMA permanent partial impairment rating or opinion into evidence. Therefore, this factor is not taken into consideration in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a correctional officer at the time of the accident and has returned to the same job without medical restrictions. The Arbitrator notes that as a correctional officer, it is clear that there is a solid likelihood that he will be involved in physical altercations due to his involvement in keeping order at a prison. The Arbitrator gives this factor moderate weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 36 years old at the time of the accident. Neither party has introduced evidence into the record which would indicate the impact of the Petitioner's age on his permanent condition. The Arbitrator gives this factor very no weight in the permanency determination

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner testified that he returned to his regular job and did not testify that his earnings have been reduced in any way due to his injury. Again, he is working with no medical restrictions, and both Dr. Gornet and Dr.

Chabot agree that he does not need such restrictions. The Arbitrator gives this factor some weight, noting that it tends to show a lesser degree of permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that according to the operative report, the Petitioner sustained a large disc herniation at C6/7 and underwent a two-level disc replacement at C5/6 and C6/7. Petitioner testified that despite the improvement from surgery and therapy, he continues to experience neck pain, which limits his hobbies including golf, motorcycling and martial arts. He takes over the counter pain medication daily and rests to reduce his pain. According to the last report of Dr. Gornet on 3/16/17, the Petitioner reported doing extremely well, and he had normal strength and sensation per the examination. He also testified that he reviewed the medical records prior to hearing and that they were accurate. Thus, there is some level of disagreement between the testimony and the records, and the Petitioner has not sought further treatment following his release by Dr. Gornet. Neither Dr. Gornet nor Respondent's Section 12 examiner Dr. Chabot believed the Petitioner required work restrictions, and the Petitioner testified he has been able to continue to perform his full work duties.

Based on the above factors, the record taken as a whole and a review of prior Commission decisions involving similar injuries and outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of 17.5% of the use of the person as a whole pursuant to §8(d)2 of the Act.

The Arbitrator notes that while this decision indicates a stipulated credit of $18,919.62 to the Respondent for paid TTD, this credit is applicable to a period of lost time that is not being claimed in this decision, which is limited to the nature and extent of the injury, and the credit is not applicable against the permanency award.

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

Luz Maria Ruiz Mendez,

Petitioner,

vs. NO: 16WC028515

Labor Network,

Respondent.

18IWCC0440

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, 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 November 6, 2017 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: JUL 17 2018
SJM/sj
o-6/28/18
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

RUIZ MENDEZ, LUZ MARIA
Employee/Petitioner

Case# **16WC028515**

LABOR NETWORK
Employer/Respondent

18IWCC0440

On 11/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
JASON BRISKI
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

5001 GAIDO & FINTZEN
JASON ALLAIN
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

18IWCC0440

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)

Luz Maria Ruiz Mendez
Employee/Petitioner

v.

Labor Network
Employer/Respondent

Case # **16** WC **28515**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **August 28, 2017 and October 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **6/26/17**, 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 alleged accident ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**18,440.96**; the average weekly wage was $**354.63**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **3** dependent children.

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

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

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

ORDER

Petitioner did not prove that she sustained accidental injuries arising out of and occurring in the course, of the employment on June 26, 2016.

Compensation, prior medical, and prospective medical are denied.

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

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

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

David A. Kane
Signature of Arbitrator

November 6, 2017
Date

ICArbDec19(b)

NOV 6 - 2017

18IWCC0440

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

Luz Maria Ruiz Mendez
Employee/Petitioner

Case # **16** WC **28515**

v.

Labor Network
Employer/Respondent

This case was heard by Honorable David Kane, Arbitrator of the Workers' Compensation Commission, in the city of Chicago, Illinois, on August 28, 2017 and October 25, 2017. After hearing the testimony and reviewing all the evidence presented, the Arbitrator hereby makes findings on the disputed issues below and includes those findings in this document.

I. FINDINGS OF FACT

Petitioner, Luz Maria Ruiz Mendez, testified that on she was working for Respondent, a staffing agency, on September 18, 2015, March 29, 2016 and June 26, 2016. (Tr. 13, 14). She testified that she was assigned by Respondent to work for another company, Clover Hill Bakery. (Tr. 13). She had been working for Respondent at Clover Hill Bakery for

approximately 14 years. (Tr. 13). She testified that she worked as a packer in the packing department. (Tr. 14).

September 18, 2015

On September 18, 2015, Petitioner testified that she was assigned to the packaging area where the product, bread, comes in big boxes ready to be shipped. (Tr. 17). She testified that the boxes were coming down altogether and that she grabbed one of the boxes and pulled it and then the other boxes came towards her. (Tr. 18). She testified that she felt pain in her right shoulder at that time. (Tr. 18). On cross-examination, Petitioner testified that it wasn't the weight of the box, or lifting the box that was the source of her pain but rather that the other boxes fell on top of her because the box she grabbed got jammed. (Tr. 62). On re-direct, Petitioner testified that the injury occurred to her arm by pulling the boxes from the conveyor belt. (Tr. 66). She testified that she reported the incident to her supervisors in the area, Norma Jaimes and Ignacio Garcia. (Tr. 20). She further testified that she continued to work following the incident and did not receive any medical care at the time. (Tr. 20; Tr. 50).

March 29, 2016

On March 29, 2016, Petitioner testified that she was working in a different packing department, though she continued to work on a conveyor belt. (Tr. 20-21). She testified that on this date, the boxes were smaller than before which meant that she had to do everything faster. (Tr. 21). She also testified that there was only one other person working with her on this date. (Tr. 21). She testified that the bread was coming moving down the conveyor from the left to the right. (Tr. 52). She testified that she was

holding the bread on the conveyor back with her right arm which eventually caused pain to her whole arm. (Tr. 21, 23).

She testified that she reported this incident to Jose Luis Escarpeta [sic] (Tr. 23).

She testified that after she reported this incident, she was treated with Physicians Immediate Care ("Physicians") on the same date. (Tr. 24). This was the first time that she presented to medical care for either the September 18, 2015 incident or the March 29, 2016 incident. (Tr. 50). Petitioner had complaints of right shoulder pain since March 29, 2016 which she described as sharp and moderate. (Px 1). The Petitioner indicated that she was pushing a cart when she felt pain on the right side of the back under the right shoulder blade. (Px 1). Petitioner testified at trial that she did not use a cart at all at work, though she testified that it was needed. (Tr. 53-54). She was diagnosed with myositis and intercostal pain and advised to return to work full duty. (Px 1). Petitioner testified that she continued to work as scheduled without restrictions. (Tr. 24).

Petitioner did not return to Physicians again until June 7, 2016, after an absence of two months, with complaints of ongoing pain in the middle of the right back. (Tr. 25; Px 1). Petitioner advised that she was still having pain but that she had been able to control the pain with medications at home. (Px 1; Tr. 55). Physical examination revealed tenderness of the thoracic muscles diffusely. (Px 1). The diagnosis at this time was myositis and a sprain of ligaments of the thoracic spine. (Px 1). She was released to full duty without restrictions. (Px 1).

Petitioner presented to Physicians for a follow-up on June 14, 2016 stating that she was continuing to have pain in the posterior aspect of the right shoulder. (Tr. 25; Px 1). She testified and the records indicate, that

she told the physician that her shoulder only hurts when she strains it and that when at rest, her shoulder does not hurt. (Px 1; Tr. 56). At this time, she was prescribed therapy at a frequency of three (3) times per week for four (4) weeks, and was to return to full duty work without restrictions. (Px 1).

June 26, 2016

On June 26, 2016, Petitioner testified that she was working in a different area of the packaging department but continued to work on a conveyor belt packing bread. (Tr. 27). On this date, Petitioner testified that she was packaging a different type of bread. (Tr. 28). That she had to grab three boxes, so that she could place them in a bigger box (Tr. 28). She testified that like the incident of March 29, 2016, she was holding back the bread as it was coming down the conveyor and that's when she felt pain again. (Tr. 28).

On June 27, 2016, Petitioner returned to Physicians for a follow-up. (Tr. 26; Px 1). She indicated that therapy had been helping with her pain but that she believed that she reinjured the area while she was working as a packer on the prior date. (Px 1). Petitioner testified and the records reflect that in addition to the pain in her right shoulder, she also noted numbness/tingling. (Tr. 29; Px 1). However, as to the severity of pain, Petitioner stated that it had decreased since her prior visit. (Px 1). Petitioner was prescribed a work restriction of avoiding strong gripping with her right hand and to limit repetitive motion with the right hand until her recheck appointment of July 11, 2016. (Px 1).

Petitioner returned to Physicians for a follow-up on July 12, 2016. (Tr. 30; Px 1). Petitioner noted that she had improvement with therapy but that

she was now experiencing pain and swelling with numbness of the right hand since her prior visit. (Px 1). However, physical examination revealed a normal arm, elbow, forearm, hand and wrist. (Px 1). Additionally, no swelling or tenderness of the wrist or hand were noted. (Px 1). She was given a work restriction of avoiding strong gripping with the right hand and to limit repetitive motion with the right hand and to wear a splint as directed until her recheck appointment of July 19, 2016. (Px 1).

On July 19, 2016, returned to Physicians for a follow-up. (Tr. 30; Px 1). Petitioner noted continued pain in her right shoulder. (Px 1). Petitioner testified and the records reflect that she now had pain going into the neck. (Tr. 31; Px 1). Physical examination only revealed moderate tenderness and swelling of the right trapezius muscle. (Px 1). She was given a work restriction of avoiding strong gripping with the right hand and to limit repetitive motion with the right hand until her recheck appointment of July 26, 2016. (Px 1).

On August 2, 2016, Petitioner returned to Physicians for a re-check. (Tr. 32; Px 1). Petitioner noted continued pain the posterior aspect of her neck. (Px 1). A trigger point injection was performed and she was prescribed therapy at a frequency of three (3) times a week for (4) weeks. (Tr. 33; Px 1). Petitioner testified that she attended therapy. (Tr. 33). However, the records indicate that she only attended 6 of the 12 prescribed sessions from June 14, 2016 and 8 of the 12 sessions from the August 2, 2016 prescribed course. (Px 1). The Arbitrator notes that this is a little more than one-half of the prescribed sessions. She continued to work per the prior restrictions with a follow-up appointment of August 16, 2016. (Tr. 33; Px 1).

Petitioner returned to Physicians on August 16, 2016 with complaints of numbness and tingling in the right upper extremity and neck. (Px 1). She was to begin therapy as previously instructed and avoid strong gripping with the right hand. (Px 1).

On August 30, 2016, Petitioner presented to Physicians for a follow-up. (Px 1). She noted that her pain severity was mild, as compared to a 4/10 on her previous visit. (Px 1). She again noted improvement with therapy but that she continued to have pain in the shoulder with extension and the back of the neck. (Px 1). She was advised to continue therapy and to avoid strong gripping with the right hand and limit repetitive motion with the right hand. (Px 1).

Petitioner returned to Physicians on September 13, 2016 with continued pain in the right trapezius area. (Px 1). On this visit, an MRI of the right shoulder was ordered. (Px 1). She was also advised to continue therapy and to avoid strong gripping with the right hand and limit repetitive motion with the right hand. (Px 1).

Petitioner testified that she received a letter from Respondent, on September 13, 2016, which indicated that she had exceed the 12 weeks limit of restricted duty work and therefore her employment would end but would be reincorporated once she was released without any restrictions. (Tr. 37). Furthermore, that according to policy, she was to receive payment for incapacity which totals the amount of 66-2/3rds of her average salary weekly at the time of the incident, as labor compensation. (Tr. 37). Petitioner further testified that she did not receive any disability payments from September 14, 2016 to the date of the hearing. (Tr. 39). Petitioner also testified that she has not returned to work for Respondent since September 13, 2016. (Tr. 39).

Dr. Markarian

Petitioner then presented to medical care with Dr. Markarian on September 28, 2016 for an initial consultation. (Tr. 39, Px 2). She advised Dr. Markarian that she was hurt at work on September 20, 2015, though uncertain of the exact date. (Px 2). She indicated that the conveyor belt went really, really fast and she tried to stop it with her right arm and torque was applied to her right shoulder when she tried to stop the boxes from moving. (Px 2). She advised Dr. Markarian that she continued to work on the line, and in 2-3 months after the initial incident, reported the incident again. (Px 2). She advised that she was prescribed medication and did not improve at all. (Px 2). Physical examination demonstrated pain in the impingement arc, full range of motion, no tenderness of the AC joint but tenderness over the long head of the biceps, rotator cuff. (Px 2). She was diagnosed with rotator cuff tendinitis with bicipital tendinitis. (Px 2). Dr. Markarian recommended an MRI, x-rays, and off work status. (Tr. 40; Px 2).

Petitioner underwent the MRI for her right shoulder on October 12, 2016. (Tr. 40, Px 3). Per the radiologist, Dr. Goldstein, his impression was that Petitioner had a high-grade partial tearing of the supraspinatus insertion with acromioclavicular joint arthropathy with inferior spurring. (Px 3). Furthermore, he noted that the rotator cuff muscles were intact without evidence of atrophy or edema and that there were no abnormal fluid collections, soft tissue masses or space occupying lesions. (Px 3). X-ray as interpreted by Dr. Aikenhead, was essentially a negative examination of the right shoulder. (Px 3).

On October 26, 2016, Petitioner returned to Dr. Markarian after completing the MRI and x-rays. (Px 2). Dr. Markarian indicated that the MRI revealed a right shoulder high-grade partial thickness rotator cuff tear of the anterodistal supraspinatus. (Px 2). Physical examination showed tenderness over the long head of the biceps and tenderness to palpation over the rotator cuff when the arm was brought into extension, abduction and external rotation. (Px 2). Dr. Markarian's diagnosis remained as a high-grade partial thickness rotator cuff tear and bicipital tendinitis. (Px 2). He recommended a right shoulder arthroscopy, bicep tenotomy, subacromial decompression, arthroscopic rotator cuff repair and open subpectoral bicep tenodesis. (Px 2).

Petitioner would follow-up again with Dr. Markarian from November 9, 2016 to October 11, 2017 wherein he maintained the prior surgical recommendation, off work restriction, and noted that Petitioner's condition had unchanged. (Px 2). The Arbitrator notes that no additional therapy or medication was prescribed by Dr. Markarian during his treatment with Petitioner. (see Px 2).

Dr. Lieber / Section 12 Examination

Petitioner was examined by Dr. Lawrence Lieber for an Independent Medical Examination (IME) on February 9, 2017 with an interpreter. (Rx 1, p. 8, 52). Dr. Lieber is an Illinois licensed, board certified orthopedic surgeon with a focus on the upper and lower extremities as well as the shoulders, hips, knees, and ankles. (Rx 1, p. 6). He is published in the area of orthopedics and performs approximately 400 – 700 surgeries per year. (Rx 1, p. 26).

At the examination, Petitioner provided a history of three (3) alleged work injuries associated with her employment. (Rx 1, p. 10-11). According to the Petitioner, she stated that on September 18, 2015, she was packaging boxes on an assembly line of about 8 pounds each. (Rx 1, p. 10). The boxes were building up and in attempting to speed up the production line, she grabbed a box and one of the other boxes pushed forward and struck her back area. (Rx 1, p. 10). She did not fall to the ground but felt a sharp pain in her shoulder, shoulder blades, and neck. (Rx 1, p. 10). The Arbitrator notes that Dr. Lieber testified that the history regarding the mechanism of injury that Petitioner gave to Dr. Markarian was different than the history she gave to Dr. Leiber. (Rx 1, p. 35).

She advised that a second incident occurred on March 15, 2016, wherein she was working on a conveyor belt where a significant amount of boxes were coming down the line. (Rx 1, p. 11). While grabbing, packaging, and pushing multiple boxes, she felt pain in her neck, shoulder and upper back area. (Rx 1, p. 11). Lastly, she gave a history of a final incident where she was again working on a conveyor belt when she developed pain while pushing a box and lifting boxes on a regular basis. (Rx 1, p. 11).

Petitioner described constant pain in her neck along with radiation down her right arm. (Rx 1, p. 12). She indicated that her right arm and shoulder pain was worse than her neck pain. (Rx 1, p. 12). She complained of pain in her neck with overhead activity as well as motion and lifting. (Rx 1, p. 12). She complained of pain in her neck with bending and ambulation. (Rx 1, p. 12). She also complained of right shoulder pain on a consistent basis with increased severity due to overhead activity. (Rx 1, p. 12). She noted pain in her shoulder at night as well as stiffness about her shoulder.

(Rx 1, p. 12-13). She also complained of swelling about her shoulder with popping and weakness. (Rx 1, p. 13). Petitioner also denied any prior history of shoulder problems. (Rx 1, p. 12).

Dr. Lieber performed a physical examination of Petitioner as part of his examination. (Rx 1, p. 13). He noted that she was tender to palpation about the paracervical muscle areas. (Rx. 1, p. 13). That she showed decreased range of motion of the neck to flexion, extension, lateral bending left and right, lateral rotation left and right, due to pain with the remainder of the cervical spine being otherwise normal. (Rx 1, p. 14). Concerning the shoulder, she had decreased range of motion due to pain about all motions of the shoulder. (Rx 1, p. 14). She showed evidence of tenderness about the biceps tendon as well as evidence of impingement, apprehension, speed, O'Brien and reverse O'Brien signs along with a lift-off sign. (Rx 1, p. 14). She also showed weakness of 4 plus over 5 due to pain to internal and external rotation and weakness of the supraspinatus and deltoid muscle. (Rx 1, p. 14). He noted that the positive O'Brien and reverse O'Brien signs are indicative of impingement and AC joint arthritis respectfully. (Rx. 1, p. 15).

In-connection with the IME report, Dr. Lieber also reviewed records from Orthopedic Associates of Naperville, an MRI report from Archer Open MRI of October 12, 2016, and records from Physicians Immediate Care. (Rx 1, p. 13). Dr. Lieber noted that the MRI report confirmed the evidence of a supraspinatus rotator cuff tendinopathy along with AC joint arthritis and spurring. (Rx 1, p. 13). He further noted that there were no acute findings on the MRI but that it was a long-standing disease process that was going on in her shoulder. (Rx 1, p. 40). Such acute changes would include edema, acute soft tissue swelling, or bone bruising. (Rx. 1, p. 41). The

Arbitrator notes that none of the medical treatment records submitted into evidence refer to any of the aforementioned, acute changes. Lastly, though he did not review the MRI scan, Dr. Leiber opined that his opinion most likely would not change. (Rx 1, p. 16).

After his physical examination of Petitioner and reviewing the medical records, he concluded that Petitioner had cervicalgia (neck pain), rotator cuff tendinitis, and AC joint arthritic right shoulder. (Rx 1, p. 16). He elaborated that the rotator cuff impression was due to the findings as confirmed by the MRI as well as the history and subjective complaints in his exam. (Rx 1, p. 17). The cervicalgia and AC joint arthritis, he noted was based upon the history, physical exam, and his own medical knowledge. (Rx 1, p. 17). He further noted that Petitioner's subjective complaints were out of proportion to the underlying objective problems in that he felt that Petitioner could have done better from a standpoint of strength and motion complaints, based upon his exam in conjunction with the reports and records. (Rx 1, p. 17). He concluded that there was definite symptom magnification. (Rx 1, p. 18).

Dr. Lieber noted that the preexisting AC joint arthritis and rotator cuff tendinitis of the right shoulder had no relationship to the alleged incidents because they are degenerative processes, and the isolated events weren't traumatic enough to cause those findings nor were the isolated events enough to progress the further degeneration of those findings. (Rx 1, p. 18). He further elaborated that whether the mechanism of injury was that which Petitioner gave to him or Dr. Markarian, that it would not have been a significant enough of an event to cause Petitioner to continue to be symptomatic at the time of his examination. (Rx 1, p. 36). Furthermore, even if she put her arm out to stop product on the belt, it would not have a

significant enough forceful impact to cause her condition. (Rx 1, p. 36-37). In this regard, he indicated that there was no causal relationship between the work events and that of the underlying cervicalgia and rotator cuff AC joint arthritis shoulder problems. (Rx 1, p. 18-19).

He opined that Petitioner's medical care was reasonable and appropriate based upon the complaints that Petitioner had. (Rx 1, p. 20). However, he felt that the right shoulder surgery recommended by Dr. Markarian was not necessary or needed as it relates to the work incidents because there was no objective evidence of any abnormality from the MRI as well as his exam. (Rx 1, p. 20). He further stated that even if the surgery was warranted, it would not be due to the work incidents. (Rx 1, p. 20). Dr. Lieber stated that in his opinion, Petitioner had not exhausted the normal conservative treatment for a partial rotator cuff tear, which includes cortisone injections, anti-inflammatories, and therapy. Further stating that "you just don't operate on this problem" as "70 to 80 percent of people with her problem get better with conservative treatment". (Rx 1, p. 40).

He opined that Petitioner did not need any activity limitations or modifications. (Rx 1, p. 21). He believed that the Petitioner was at maximum medical improvement as of the IME visit. (Rx 1, p. 21).

Dr. Pontinen

Dr. Markarian eventually referred Petitioner to Dr. Pontinen, a pain management specialist, for additional treatment. (Px 7; Tr. 41). Petitioner was examined by Dr. Pontinen on two occasions. (See Px 7; Tr. 42). Petitioner first presented to Dr. Pontinen on May 23, 2017. (Px 7). Petitioner presented with complaints of severe/chronic right shoulder, low back and neck pain. (Px 7). She described the pain to Dr. Pontinen as

constant in nature and at a 6-8/10, worsened with flexion and activity and improved with rest. (Px 7). Dr. Pontinen noted that her pain radiated to the right arm and right leg in the C7-8 and L4-S1 distributions. (Px 7). He further noted no neurological deficit such as numbness or weakness. (Px 7). He diagnosed Petitioner with cervicalgia (neck pain), bursitis of the right shoulder, low back pain, and radiculopathy of the lumbar and cervical region. (Px 7). He recommended a cervical and lumbar MRI for the cervical and lumbar radicular pain and for Petitioner to remain off work until after the recommended shoulder surgery. (Px 7).

Petitioner underwent MRIs of the cervical and lumbar spine on May 25, 2017 with Edgebrook Radiology. (Px 6). Per the radiologist report, regarding the MRI of the lumbar spine, his impression was of a 3-4 mm broad-based posterior disk herniation which indents the thecal sac with mild bilateral neuroforaminal narrowing, slightly exacerbated by some ligamentum flavum hypertrophy and mild facet arthrosis. (Px 6). As to the cervical spine, the radiologist noted abnormal straightening and reversal of the usual cervical curvature, and a 2 mm posterior annular disk bulge which indents the ventral surfaces of the thecal sac at the C5-6 and C6-7 levels. (Px 6).

Petitioner revisited Dr. Pontinen on June 6, 2017 presenting with the same symptoms and complaints as the previous visit. (Px 7). He reviewed the MRIs of May 25, 2017 as well as the IME report of Dr. Lieber. (Px 7). Dr. Pontinen suggested treatment in the form of a cervical epidural steroid injection for continued cervical radicular pain. In response to the IME report of Dr. Lieber, Dr. Pontinen stated that he does not know how Dr. Lieber could conclude that Petitioner's work incident could not have caused her current condition. (Px 7). He noted that Petitioner's job requires lifting and

moving objects constantly at a fast rate all day and that at any time, a disc herniation or rotator cuff could have easily occurred. (Px 7).

Wages

Regarding her wages, Petitioner testified that her pay rate was at $10.25/hour increasing to $10.50/hour during the last months when she was working. (Tr. 15). She testified that her normal work schedule was from 2 a.m. until 2 p.m., four to five days per week. (Tr. 15). She testified that her schedule did not vary based upon production demands but did depend upon prior scheduling. (Tr. 16).

The Respondent called Michelle Urbieta to testify regarding the specific issue of the Wage Statements and overtime requirements in this case. Ms. Urbieta, manager for Respondent, testified that she is responsible for payroll, accounting and oversight of hours for Respondent's employees. She testified that she was also familiar with the Petitioner. She testified that she was familiar with the Wage Statements and that they were fair and accurate copies of the Employee Wage Statement of Luz Maria Ruiz Mendez for checks with a check date between September 18, 2014 and November 7, 2016. She testified that these statements were kept under her custody and control and that it was a regular part of her business to keep and maintain records of this type.

In regard to the overtime requirements for Petitioner, though she was not directly responsible for the scheduling of Petitioner's hours, Ms. Urbieta testified that Petitioner's hours when compared with other similarly situated employees were not consistent in terms of overtime. (*See* Rx 2).

At trial, Respondent submitted into evidence, Respondent's Exhibit #2, the Employee Wage Statement of Luz Maria Ruiz Mendez for checks

with a check date between September 18, 2014 and November 7, 2016. (Rx 2).

Petitioner testified that she was not married with three children under the age of 18. (Tr.10). Petitioner testified that all three children were born in Chicago, Illinois. (Tr. 12).

II. CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to (C), whether the accident arose out of and in the course, of Petitioner's employment, the Arbitrator finds the following:

Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment with Respondent on September 18, 2015, March 29, 2016 or June 26, 2016.

It is well-established that a Petitioner carries the burden of proving her case beyond a preponderance of the evidence. "Preponderance of the evidence is evidence which is of greater weight, or more convincing than the evidence offered in opposition of it; it is evidence which as-a-whole shows that the fact to be proved is more probable than not." Houck v. Nationwide Rail Service, 11 IWCC 249, citing, Jones v. J. Rubin, 02 IIC 142; [Note, the compensability holding in Houck was overturned at the Circuit Court on other grounds] Parro v. Industrial Commission, 630 N.E.2d 860 (1st Dist. 1993); Central Rug & Carpet v. Industrial Commission, 838 N.E.2d 39 (1st Dist. 2005).

Among the factors to be considered in determining whether a claimant has sufficiently carried her burden, is the credibility of declarant. See, Houck, supra. Credibility is the quality of a witness, which renders their evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness's demeanor and any external inconsistencies with testimony and/or medical evidence.

A claimant bears the burden of proving by a preponderance of the evidence that his injury arose out of and in the course, of the employment. 820 ILCS 305/2. Both elements must be present in order, to justify compensation. Illinois Bell Telephone Co. v. Industrial Commission, 131 Ill. 2d 478 (1989).

The phrase "in-the course of" refers to the time, place, and circumstances under which an incident occurred. Orsini v. Industrial Commission, 117 Ill. 2d 38 (1987). The words "arising out of" refer to the origin or cause of the incident and presuppose a causal connection between the employment and the accidental injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52 (1989).

In regard to the September 18, 2015 incident, Petitioner testified that the boxes were coming down altogether and that she grabbed one of the boxes and pulled it and then the other boxes came towards her. (Tr. 18). On cross-examination, Petitioner testified that it wasn't the weight of the box, or lifting the box that was the source of her pain but rather that the other boxes fell on top of her because the box she grabbed got jammed. (Tr. 62). On re-direct, Petitioner testified that the injury occurred to her arm by pulling the boxes from the conveyor belt. (Tr. 66).

When Petitioner first presented to Dr. Markarian, she indicated that the conveyor belt went really, really fast and she tried to stop it with her right arm and torque was applied to her right shoulder when she tried to stop the boxes from moving. (Px 2). However, when Petitioner presented to Dr. Lieber, she stated that on September 18, 2015, she was packaging boxes on an assembly line of about 8 pounds each. (Rx 1, p. 10). The boxes were building up and in attempting to speed up the production line, she grabbed a box and one of the other boxes pushed forward and struck her back area. (Rx 1, p. 10). She did not fall to the ground but felt a sharp pain in her shoulder, shoulder blades, and neck. (Rx 1, p. 10).

Here, the Arbitrator finds that Petitioner provided various histories both at trial and to the treating and examining physicians regarding the mechanism of injury. At trial, she testified to a jerking motion as well as being struck with boxes. When she presented to Dr. Markarian she indicated that she attempted to stop a conveyor belt when torque was applied to her right shoulder. Conversely, with Dr. Lieber she indicated that she was struck in the back area after grabbing a box. Accordingly, the Arbitrator does not find Petitioner credible with respect to her varying descriptions regarding the mechanism of injury for the September 18, 2015 incident.

In regard to the March 29, 2016 incident, Petitioner testified at trial that she was working in a different packing department, though she continued to work on a conveyor belt. (Tr. 20-21). She testified that on this date, the boxes were smaller than before which meant that she had to do everything faster. (Tr. 21). She testified that the bread was coming moving down the conveyor from the left to the right. (Tr. 52). She testified that she

was holding the bread on the conveyor back with her right arm which eventually caused pain to her whole arm. (Tr. 21, 23).

According to the treatment records from Physicians, Petitioner advised that she was pushing a cart when she felt pain on the right side of the back under the right shoulder blade. (Px 1). Though she testified at trial that she did not use a cart at all at work, but that it was needed. (Tr. 53-54).

When Petitioner presented to Dr. Leiber, she advised that she was working on a conveyor belt where a significant amount of boxes were coming down the line. (Rx 1, p. 11). While grabbing, packaging, and pushing multiple boxes, she felt pain in her neck, shoulder and upper back area. (Rx 1, p. 11).

Here, the Arbitrator finds the Petitioner un-credible regarding the mechanism of injury. Petitioner provided various histories both at trial and to the examining and treating physicians. At trial, Petitioner testified that she was holding the bread back as it was on the conveyor, which caused pain to her arm. However, when she presented to medical care, she advised that she was pushing a cart, though she testified at trial that she did not use a cart at all at work.

Furthermore, the Arbitrator notes that the history supplied at trial makes little sense in terms of the physical movements that Petitioner was attempting at the time. Petitioner, who was right hand dominant, testified that the boxes were moving from the left to the right on the conveyor, yet, the Petitioner testified that she was holding back the boxes with her right hand, as she was filling boxes that held bread as the bread was accumulating. (Tr. 52). Therefore, Petitioner would be reaching across her body with her right arm, as she was filling boxes with her left arm, crossed over the right arm, which was holding back the boxes. Otherwise, she

would have been filling boxes behind her back. This physical movement seems highly impractical and unusual given the scenario that Petitioner described. As such, the Arbitrator does not find Petitioner credible with respect to her varying descriptions of the March 29, 2016 incident.

Lastly, in regard to the June 26, 2016 incident, Petitioner testified that she was working in a different area of the packaging department but continued to work on a conveyor belt packing bread. (Tr. 27). On this date, Petitioner testified that she was packaging a different type of bread. (Tr. 28). That she had to grab three boxes, so that she could place them in a bigger box (Tr. 28). She testified that like the incident of March 29, 2016, she was holding back the bread as it was coming down the conveyor and that's when she felt pain again. (Tr. 28).

However, when she presented to Dr. Lieber, she gave a history of a final incident where she was again working on a conveyor belt when she developed pain while pushing a box and lifting boxes on a regular basis. (Rx 1, p. 11).

The Arbitrator notes that the description provided to Dr. Lieber indicates an injury of a repetitive nature and not an acute one as Petitioner testified to at trial. There is also a disparity regarding the history supplied to Dr. Lieber versus what Petitioner testified to at trial. The Arbitrator does not find the Petitioner credible with respect to her descriptions of the June 26, 2016 incident.

Applying the applicable case law to the above-captioned matter, based on the totality of the circumstances and weighing the credibility of the witnesses; the Arbitrator concludes that the Petitioner failed to sustain

her burden of proof by a preponderance of evidence that she sustained accidental injuries arising out of and occurring in the course, of employment with the Respondent.

In support of the Arbitrator's decision relating to (E), whether timely notice of the alleged accidents was given to Respondent, the Arbitrator finds as follows:

Petitioner's testimony regarding timely notice was unrebutted in all three cases and the Arbitrator finds that Petitioner gave timely notice of the alleged accidents in all three cases. :

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

The Arbitrator has separately decided on the issue of accident. However, causal connection as it relates to Petitioner's alleged condition of ill-being in the shoulder and back were placed in dispute and is important for discussion, particularly as related to the issue of "accident". Petitioner carries the burden of proving her case by a preponderance of the evidence and Petitioner's recounting of the alleged accident and subjective pain complaints are inconsistent with the objective medical records and completely unreliable.

Right Shoulder

In regard to the shoulder, the Arbitrator finds the opinion of Dr. Lieber to be most instructive and most credible here, especially in regard to his interpretation of the MRI of the right shoulder. According to Dr. Lieber, Petitioner had preexisting AC joint arthritis and rotator cuff tendinitis of the right shoulder which had no relationship to the alleged incidents because they are degenerative processes, and the isolated events weren't traumatic enough to cause those findings nor were the isolated events enough to progress the further degeneration of those findings. (Rx 1, p. 18).

In his deposition testimony, Dr. Lieber further elaborated that whether the mechanism of injury was that which Petitioner gave to him or Dr. Markarian, it would not have been a significant enough of an event to cause Petitioner to continue to be symptomatic at the time of his examination. (Rx 1, p. 36). Furthermore, he noted that even if she put her arm out to stop product on the belt, it would not have a significant enough forceful impact to cause her condition. (Rx 1, p. 36-37).

Dr. Lieber also noted that though the MRI report confirmed the evidence of a supraspinatus rotator cuff tendinopathy along with AC joint arthritis and spurring, there were no acute findings on the MRI. He elaborated that it was a long-standing disease process that was going on in her shoulder. (Rx 1, p. 13, 40). Such acute changes would include edema,

acute soft tissue swelling, or bone bruising. (Rx. 1, p. 41). The Arbitrator notes that none of the medical treatment records submitted into evidence refer to any of the aforementioned, acute changes.

Furthermore, the Arbitrator finds that the only other causation opinion submitted into evidence is that of Dr. Pontinen, a pain specialist, not an orthopedic surgeon like Dr. Lieber. There is no causation opinion in the records from Petitioner's other treating physicians, including Dr. Markarian. Dr. Pontinen opined that Petitioner's job requires lifting and moving objects constantly at a fast rate all day and that at any time a rotator cuff tear could have occurred. He goes on to state that Dr. Lieber does not address "the torn rotator cuff in his plan and explain how this can only be a chronic injury". However, as the Arbitrator just indicated, Dr. Lieber specifically addresses this exact statement in his evidence deposition when he indicated that were this an acute injury, there would have been acute changes which would have appeared in the MRI of the right shoulder, which there were not. Therefore, the Arbitrator does not find the opinion of Dr. Pontinen credible here.

Back / Neck

As to Petitioner's back, the Arbitrator notes that when Petitioner presented for an initial evaluation with Dr. Markarian on September 28, 2016, Petitioner only complained of right shoulder pain. In fact, Dr. Markarian's records make no mention of Petitioner complaining of neck or lower back pain.

When she presented for examination with Dr. Lieber, the Arbitrator notes that report indicates complaints in her neck along with radiation down

her right arm, but Petitioner indicated that her right arm and shoulder pain was worse than her neck pain. Petitioner makes no complaints regarding low back. Dr. Lieber diagnosed Petitioner with cervicalgia (neck pain) and stated that her back and upper neck pain is related to soft tissue myositis that has no relationship to the alleged work events.

In fact, the Arbitrator finds that it was not until Petitioner began treating with Dr. Pontinen, a pain specialist, nearly a year after the last alleged incident, that Petitioner had complaints of low back pain.

Shell Oil v. Industrial Commission, 2 Ill. 2d 590 (1954), is instructive here. In that case, it was astutely observed that "declarations of an injured person to a treating physician as to his physical condition, and the cause thereof, are admitted into evidence for the reason that it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid." Id. *citing,* Shaughnessy v. Holt, 236 Ill. 485 (1908).

Similar language was cited by the Supreme Court in Jensen v. Elgin, Joliet and Eastern Railway Company, 24 Ill. 2d 383 (1962), for the proposition that the desire for proper treatment outweighs any motive to falsify. By way of general evidentiary concepts, greater weight is ordinarily afforded to contemporaneous medical records and histories, instead of later, less reliable and self-serving histories by those who have had time to formulate statements.

After considering all medical opinions, the Arbitrator concludes that Petitioner's claimed condition of ill-being in her right shoulder, cervical spine and lumbar spine are not causally related to her employment with Respondent. Specifically, the Arbitrator finds the opinion of Dr. Lieber to be

the most credible here in that the underlying abnormalities show evidence of a preexisting condition which were neither caused, associated, or related to work events.

In-connection with the Arbitrator's Decision regarding Issue G, Petitioner's earnings, the Arbitrator concludes as follows:

In dispute at Trial were Petitioner's earnings. Entered into evidence was a copy of Petitioner's wage statement for the 52 weeks prior to the September 18, 2015 incident, March 29, 2016 incident, and June 26, 2016 incident. (Rx 2). Petitioner testified that she had been working for Respondent at Clover Hill Bakery for approximately 14 years. (Tr. 13). She testified that her normal work schedule was from 2 a.m. until 2 p.m., four to five days per week. (Tr. 15). She testified that her schedule did not vary based upon production demands but did depend upon prior scheduling. (Tr. 16).

In regard to the overtime requirements for Petitioner, though she was not directly responsible for the scheduling of Petitioner's hours, Ms. Urbieta, witness for Respondent, testified that Petitioner's hours when compared with other similarly situated employees were not consistent in terms of overtime. *See* Rx 2.

The facts in Freesen are similar here. Freesen, Inc v. Industrial Commission, 348 Ill. App. 3d 1035 (2004). In Freesen, Petitioner proved that he worked overtime in 22 of the 45 weeks he worked prior to the accident and the Commission included his OT hours in the wage calculation. The Appellate Court reversed and held that the overtime would

be excluded because there was "no evidence that (1) he was required to work overtime as a condition of his employment, (2) he consistently worked a set number of overtime hours each week, or (3) the overtime hours he worked were part of his regular hours of employment."

The Arbitrator notes, pursuant to the Employee Wage Statement, Petitioner had inconsistent hours during the periods in question. Respondent's witness, also testified that Petitioner's hours were inconsistent. Moreover, Petitioner failed to testify that overtime was mandatory. Consistent with Section 10 of the Act, the Arbitrator concludes it is not appropriate for the average weekly wage to be computed with overtime hours.

As indicated by Petitioner's wage statement, regarding the September 18, 2015 incident, in the year proceeding, Petitioner earned $15,570.21, with an average weekly wage of $299.43. Regarding the March 29, 2016, in the year proceeding, Petitioner earned $18,498.77, with an average weekly wage of $355.75. Regarding the June 26, 2016 incident, in the year proceeding, Petitioner earned $18,440.96, with an average weekly wage of $354.63.

Due to the Arbitrator's findings on the issues of accident and causal relationship, all other issues are rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Luz Maria Ruiz Mendez,

Petitioner,

vs. NO: 16WC028516

Labor Network,

18IWCC0441

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, 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 November 6, 2017 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: JUL 17 2018
SJM/sj
o-6/28/18
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

RUIZ MENDEZ, LUZ MARIA
Employee/Petitioner

Case# **16WC028516**

18IWCC0441

LABOR NETWORK
Employer/Respondent

On 11/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
JASON BRISKI
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

5001 GAIDO & FINTZEN
JASON ALLAIN
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

18IWCC0441

☐ 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)

Luz Maria Ruiz Mendez
Employee/Petitioner
v.
Labor Network
Employer/Respondent

Case # **16** WC **28516**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **August 28, 2017 and October 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **9/18/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this alleged 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 **$15,570.21**; the average weekly wage was **$299.43**.

On the date of accident, Petitioner was **43** years of age, *single* with **3** dependent children.

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

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

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

ORDER

Petitioner did not prove that she sustained accidental injuries arising out of and occurring in the course, of the employment on September 18, 2015.

Compensation, prior medical, and prospective medical are denied.

See Arbitration Decision 19(b) in consolidated case 16 WC 28515 for findings of fact and conclusions of law.

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

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

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

David A. Kane
Signature of Arbitrator

November 6, 2017
Date

ICArbDec19(b)

NOV 6 - 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bethzaida Febus

Petitioner,

vs.

NO: 15WC002495

Roundy's Illinois LLC d/b/a Mariano's

18IWCC0442

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 24, 2017 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: JUL 17 2018
SJM/sj
o-6/28/18
44

Stephen J. Mathis

Deborah L Simpson

David L. Gore

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

FEBUS, BETHZAIDA
Employee/Petitioner

Case# **15WC002495**

ROUNDY'S ILLINOIS LLC D/B/A MARIANO'S
Employer/Respondent

18IWCC0442

On 10/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% 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:

5177 LAW OFFICE LEONARDO MORALES PC
53 W JACKSON BLVD
SUITE 1750
CHICAGO, IL 60604

5196 CLAYBORNE SABO & WAGNER LLP
JENNIFER L BARBIERI
525 W MAIN ST SUITE 105
BELLEVILLE, IL 62222

State of Illinois)

COUNTY OF Cook)

18IWCC0442

☐ 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)

Bethzaida Febus
Employee/Petitioner

v.

Roundy's Illinois LLC, d/b/a Mariano's
Employer/Respondent

Case # **15** WC **2495**

Consolidated cases: _____

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

DISPUTED ISSUES

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

18IWCC0442

FINDINGS

On the date of accident, **December 6, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *was* given to Respondent. Because the Arbitrator finds no accident, the remaining disputed issues of causal connection, liability for unpaid medical bills, temporary total disability, prospective care and penalties and fees are hereby rendered MOOT.

In the year preceding the injury, Petitioner earned **$11,768.80**; the average weekly wage was **$226.33**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. Respondent is entitled to a credit of **$2,957.46** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she suffered an accident arising out of and in the course of her employment. Because the Arbitrator finds no accident, the remaining disputed issues of causal connection, liability for unpaid medical bills, temporary total disability, prospective care and penalties and fees are hereby rendered MOOT.

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

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

Signature of Arbitrator

10-23-2017
Date

ICArbDec19(b)

OCT 24 2017

18IWCC0442

FINDINGS OF FACT

Bethzaida Febus (Petitioner) pursued this matter pursuant to the Workers' Compensation Act seeking relief from her employer, Roundy's Illinois, LLC, d/b/a Mariano's (Respondent). By agreement of the parties, this matter proceeded to an emergency hearing under Section 19(b) on 8/17/1717. The following is a recitation of the facts adduced at trial.

On 12/6/14, Petitioner was employed as an overnight baker by Respondent. Some of her duties included lifting boxes filled with bread in order to make room in the freezer that she was working on. On that date, Petitioner testified she injured her lower back after she lifted boxes weighing approximately 10 lbs. to 30 lbs. Petitioner immediately began experiencing pain in her lower back and in her legs. Because Petitioner believed that the pain would go away, she did not initially notify her supervisor on that date, but did provide notice to her supervisor on 12/12/14, after she was told by her doctor that she was to remain off of work. Petitioner filled out an injury report detailing the work injury. Px5. According to that report, Petitioner relayed that on 12/6/14 at approximately 3 AM she was lifting boxes from the floor to move flat carts out of the way for doughnut break out in the freezer. She identified her lower back or spine as the body part injured. The nature of her injury or symptoms as described was back spasms, trouble standing, sitting, moving or lifting.

Petitioner did not seek treatment right away because she thought her pain would go away. On 12/8/14, Petitioner presented to the emergency room at Stroger Hospital, after blacking out at home. Px1. She noted a flair of back pain with radiation down the right leg. Assessment was syncope but she was to be evaluated for cardiac cause. Neurologic cause was ruled out per normal neuro exam. She also complained of neck pain status post fall. X-rays of the cervical spine were normal. X-rays of the spine we're also normal.

On 12/16/14, Petitioner returned to Stroger Hospital due to the shortness of breath, abdominal pain and headache. Another emergency department clinical summary record noted Petitioners reason for visit with shortness of breath and hip pain. Petitioner was given education information for fainting. Petitioner reported that since the last time she was at the emergency room, she continued to experience exertional shortness of breath with minimal activity. Additionally, she stated that when she lost her consciousness, she hit her head on the table and hard floor and that since then she had been having headaches. The doctor noted that there was no clear cause of her shortness of breath.

On 1/2/15, Petitioner returned to Stroger. Chief complaint was numbness, back pain to both lower extremities. Petitioner related she injured at work while lifting and begin having lower back pain. She returned because for the last week she had been having bilateral lower extremity numbness and weakness. She reported that the numbers began in her toes then gradually spread to her legs. Differential diagnosis was lumbar strain, sciatica and possible radiculopathy. She was prescribed baclofen and naproxen and discharged. She was encouraged to follow up with neurology. In the neurology note, tuition and related that she was lifting heavy boxes at work around Thanksgiving when she strained a muscle in her right lower back. She also reported that she had a severe spasm while sitting down eating in her kitchen and had a lot of consciousness. Petitioner also related that she recently fell out of bed secondary to the back pain. She was treated at Illinois Masonic and given medicine for pain. The doctor noted that Petitioner symptoms or likely due to spring and possible radiculopathy that could be contributing to her clinical picture. The plan was for an MRI of the lumbar spine without contrast and to follow up with Dr. Kelly.

On 12/26/14, Petitioner went to the emergency room at Advocate Illinois Masonic due to the worsening pain that she was experiencing in her back. Px2. Medical records indicated that she injured her back while

working in the bakery where she lifted a heavy object. She was diagnosed with an acute lumbar radiculopathy and low back pain. Petitioner was given work restrictions of no lifting more than 15 lbs. Px8.

On 1/14/15, Petitioner returned to Stroger Hospital complaining of left foot pain and spasms to her lower extremities. The doctor noted the lumbar spine was normal and that cause of her numbness was not evidence. Impression was back pain, foot pain without evidence of root or nerve injury. the plan was for MRI, physical therapy, follow up with primary doctor and follow up in 4 months. Petitioner was taken off work until her pain resolved. Px8. On 1/17/15, Petitioner sought treatment with Dr. Dietz, DC, at Integrity Medical Group for her low back pain and the numbness and tingling in both of her legs and feet and provided a history of the work injury. Px3. She estimated the boxes weighed between 15-50 pounds. At the time of the exam, she complained of numbness and tingling to both legs and feet. Petitioner was diagnosed with lumbosacral sprain and possible lumbar disc syndrome with radiculopathy and was ordered physical therapy. Petitioner was taken off work. Px8.

On 1/20/15, Petitioner began chiropractic care at Integrity with Dr. Iavarone, DC. Px3. On 1/21/15, Petitioner returned to Dr. Dietz and reported minimal lower back pain. px3. She endorsed mostly numbness and tingling in both legs. Assessment was unchanged and Petitioner underwent chiropractic care. On 1/22/15, a second MRI of the lumbar spine showed large herniation resulting in severe central canal stenosis with obliteration of the central canal at L4-5 and disc bulge with associated annular tear combined with congenital narrowing resulting in moderate central canal stenosis at L3-4. Px3. On 1/24/15, Petitioner returned to Integrity for chiropractic care. She was referred to Dr. Chunduri. Px3.

On 1/27/15, Petitioner saw Dr. Chunduri, MD, at Integrity. The doctor noted Petitioner was injured at work resulting in her current symptoms, which included back pain and bilateral numbness and tingling from pelvis to the toes. It was his opinion that the herniation had completely obliterated the thecal sac, resulting in severe neuro compression of the cauda equine nerves, resulting in severe decrease in sensation and weakness of her lower half of her body. The doctor felt her symptoms and diagnoses were casually related to the work injury and that his recommended treatment was reasonable and necessary. Petitioner was referred for a surgical consult with Dr. Singh and was taken off work. Px3, Px8. On 2/24/15, Integrity office notes noted that Petitioner had not yet seen the surgeon due to a lack of approval by the workers' compensation carrier and that her pain was a 4/10. Px3. She was ordered to remain off work. Px8.

On 3/23/15, Petitioner underwent an MRI of her lumbar spine which revealed a superimposed herniation at L4-5 with extruded disc fragment with inferior extension down the level of the upper L5 vertebral body, markedly effacing the ventral thecal sac and compressing the cauda equine roots. Neurogenic claudication correlation was recommended. At L3-4, there was disc bulge effacing the ventral epidural fast and partially narrowing the inferior neural foramina. There was also superimposed annual fissure and posterocentral disc protrusion effacing ventral sac and abutted the bilateral proximal L4 traversing nerve roots.

On 4/4/15, Petitioner returned to the emergency room at Stroger Hospital after abnormal MRI. Px1. She related ongoing intermittent spasms in the low back, decreased sensation in the back of her thighs, decreased walking ability, prior decreased sensation urinating and some weakness in the right leg. The plan noted the disc was compressing the cauda equine roots. A CT scan was ordered that same date, which showed central disc extrusion at L4-5. On 4/7/15, Petitioner returned to Integrity where they noted that Petitioner had not yet seen the surgeon due to a lack of approval by the workers' compensation carrier and that her pain was a 4 to 6 out of 10. Px3. She was ordered off work. Px8. She related that the surgeon at Cook County recommended a microdiskectomy. Diagnosis was lumbar disc herniation and bilateral radiculitis.

On 5/19/15, Petitioner again followed up with Integrity and they noted her pain at approximately 6 out of 10. She remained off work. Px3. Px8. On 5/21/15, Petitioner was examined by Dr. Lami at the request of Respondent. Rx2. He found no casual connection based upon her performing her normal work activities. He thought she would have remembered the incident and would have had an immediate onset of pain. He further noted that most herniations occur spontaneously and that she had degenerative changes which pre-disposed her to herniations. He noted the MRI findings as not related to any work incident.

On 6/16/15, Petitioner returned to Integrity and Dr. Chunduri noted that she continued to have ongoing pain in her back that radiated down her leg and that she had not yet seen the spine surgeon. She was taken off work. Px3, Px8. On 7/28/15, Petitioner again followed up with Integrity, and Dr. Chunduri noted that the left side pain in her back was worse and she continued to have numbness and tingling. Px3. She was ordered off work. Px8.

On 12/15/15, she followed up with Dr. Chunduri at Integrity and he noted unchanged symptoms and plan. She remained off work. Px3, Px8.

Three months later, on 3/26/16, Petitioner began treating with Suburban Orthopaedics and they noted the work injury as a result of lifting boxes at work in a freezer. Px4. Dr. Howard Freedberg noted that she had numbness and tingling in her third, fourth, and fifth toes of both of her feet as well as back pain. Dr. Freedberg disagreed with the Section 12 report authored by Dr. Lami because Dr. Lami indicated that there was no inciting event that caused the injury and that Petitioner would have remembered the incident with immediate onset of pain. Dr. Freedberg noted that he spoke to Petitioner about this, and she informed him that although she had been having some difficulty with low back pain, on December 6, 2014, she absolutely remembers her back hurting doing a lot of lifting and remembers getting pain down both legs during the lifting. Dr. Freedberg opined that she did hurt herself at work and that her condition of ill-being was causally connected to the incident of 12/6/14. Px3. Dr. Freedberg ordered Petitioner off work. Px8.On 5/11/16, Petitioner again visited Dr. Freedberg who noted that she continued to experience numbness from her buttock area into her left knee and leg. Px4. Dr. Freedberg again ordered Petitioner off work. Px8.

In his deposition, Dr. Freedberg testified under oath that Petitioner suffered from low back pain and numbness to her lower extremities due to the work accident on December 6, 2014.[1] Px6. Dr. Freedberg testified that there was a causal connection between the injury that Petitioner suffered at work and her current medical condition. He further testified that based upon a reasonable degree of medical and surgical certainty, Petitioner needed more medical treatment for her low back. He indicated that an option for Petitioner would be epidural injections. When asked what type of surgery would be recommended, the doctor said he would defer to Dr. McNally. Dr. Freedberg also testified that he was skeptical of Petitioner herniating her disc simply by falling off her bed.

In his deposition, Dr. Lami testified that Petitioner's condition was not relatable to any work event. Rx2. He testified that given her herniation, she would have experienced an immediate onset of pain and would have remembered it. never mentioned that she had a work injury to him (He then testified that lifting boxes can cause a disc herniation. Dr. Lami noted Petitioner's herniation and agreed that it could require surgery. He could not related the herniation or surgery to any work accident and accordingly felt she was at maximum medical improvement.

[1] Petitioner failed to attach any referenced deposition exhibits to the deposition transcript and/or otherwise failed to formally request or admit them into evidence at the time of the deposition and at trial.

At the hearing, Petitioner testified that she currently has pain when she is in motion and she tries to avoid lifting, going up stairs, walking long distances and bending due to the pain. Petitioner also testified that she does not think that sliding off her bed onto the floor is what caused her back pain since she slid off her bed due to the pain she was experiencing in her back. Petitioner further testified that she did not feel pain when her vehicle was crashed into and did not think her current back pain was due to the crash because the impact to her vehicle was minimal. Petitioner did not seek medical treatment for the crash.

CONCLUSIONS OF LAW

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has failed to prove by a preponderance of the evidence that an accident occurred that arose out of and in the course of Petitioner's employment by Respondent on December 6, 2014. Petitioner's testimony was that she injured her low back while lifting boxes at work. While her testimony may be unrebutted, her accident is not corroborated by any contemporaneous medical record. First, when she presented to the emergency room on 12/8/14, her chief complaint was syncope and there is no mention of a work accident. Second, when she returned to the emergency room on 12/16/14, her chief complaint was shortness of breath, abdominal pain and headache. There is no mention of low back pain or a low back injury from any work incident. The notes mention that Petitioner had been complaining of shortness of breath for one week and that she had been into the emergency room one week prior for the same complaint. Again, no mention of low back pain for one week is made. Third, on 1/5/15, Petitioner returned to Stroger and have a different history of lifting at work around Thanksgiving, which predates her alleged date of accident. While other records eventually mention an alleged low back injury at work, the Arbitrator notes that the contemporaneous medical record does not support Petitioner's version of events. The Arbitrator places little weight on Petitioner's prior motor vehicle accident and her falling out of bed as the finding of no accident is sufficiently supported by the conclusions stated herein.

In summary, there are discrepancies in the timing of the injury, the mechanism of injury and Petitioner's history is not corroborated. At trial, Petitioner failed to give adequate testimony explaining why these discrepancies exist. Based on the foregoing, the Arbitrator concludes Petitioner failed to prove accident. All remaining disputed issues are denied as moot.

Signature of Arbitrator

10-23-2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Batton

Petitioner,

vs. NO: 14WC042261

Olin Corporation/Global Brass,

Respondent.

18IWCC0443

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 18, 2017 is hereby affirmed and adopted.

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

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

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

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
SJM/sj
o-6/7/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

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

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 17 2018
SJM/sj
o-6/7/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

BATTON, MICHAEL
Employee/Petitioner

Case# **14WC042261**

OLIN CORPORATION/GLOBAL BRASS
Employer/Respondent

18IWCC0443

On 8/18/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 LAW OFFICE KEITH SHORT
1355 N BLUFF RD
UNITS C-D
COLLINSVILLE, IL 62234

0299 KEEFE & DePAULI PC
ANDREW J KEEFE
2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0443

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

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

MICHAEL BATTON
Employee/Petitioner

v.

OLIN CORPORATION / GLOBAL BRASS
Employer/Respondent

Case # 14 WC 42261

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 **Mt. Vernon**, on **May 5, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **November 26, 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*, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned **$59,088.82**; the average weekly wage was **$1,136.32**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **2** dependent children.

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

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

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

ORDER

The Arbitrator finds that the Petitioner has sustained his burden of proving an accident occurred on November 26, 2014 which arose out of and in the course of his employment with Respondent.

The Arbitrator finds that the Petitioner has sustained his burden of proving that his bilateral carpal tunnel and elbow synovitis conditions are causally related to the November 26, 2014 accident. The Petitioner has failed to prove that he has the conditions of bilateral cubital tunnel and bilateral lateral epicondylitis, and as such has failed to prove that such conditions are causally related to the November 26, 2014 accident.

Respondent shall pay reasonable and necessary medical services contained in Px4 and Px5, as provided in Sections 8(a) and 8.2 of the Act. However, the Respondent is not liable for the expenses of Dr. Solman based on his March 20, 2015 examination, as this constituted an independent medical examination requested by his attorney, and was billed as such.

Respondent shall be given a credit for any awarded medical benefits that have been paid pursuant to Sections 8(a), 8(j) and 8.2 of the Act, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

The Arbitrator finds that the need for bilateral carpal tunnel surgeries is premature at this point based on the testimony of Dr. Solman and Dr. Strecker. Respondent shall authorize an updated visit with Dr. Solman to determine if such surgery is reasonable and necessary, and if so shall authorize these surgeries, 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

August 14, 2017
Date

AUG 18 2017

STATEMENT OF FACTS

The Petitioner, a 13 year Respondent employee, testified that after working initially for two years as a forklift driver in the casting plant, he worked the next 10 years as a T500 bullet adjuster. The employer ultimately moved that job to Mississippi, but towards the end of his time in that position, Petitioner testified he would get a little occasional numbness in his hands: "My hands would fall asleep on me just from repetitive use." He next worked as an extrusion press operator starting in late 2014.

Petitioner testified he is 6'4", 350#, and has lifted weights in his life "from time to time." In the adjuster job, Petitioner maintained 3 different bullet machines. He would have to lift lead to make sure the pots were full, and did use his hands a "fair" amount. As an extruder operator, after a week of hands-on training, Petitioner testified he would load 150 pound billets of lead into the press 138 times per day. Billets are cylindrical, over a foot tall and 4-5" across, containing solid lead. A hydraulic assist crane is used, meaning both he and the machine take on some of the weight. When he moved to the extruder job, Petitioner testified that the constant lifting, pushing and pulling caused symptoms in his hands and elbows. He testified: "You're holding two handles in front of you, and you have grab and release buttons on the handles." He would do this with his arms and elbows at his sides at a 90 degree angle, as if in the middle of performing arm curls, and he would use both hands to lift, turn and push it into the machine. He testified he would: "Pull back, set it on the pedestal, lubricate it, grip it again, push it forward into the machine and drop it." He testified that it felt like the force required to do this was about 50 to 60 pounds.

In describing the task in more detail on cross exam, the Petitioner testified: "You're holding two vertical handles that swing, so you're lifting up and the handles move, so you got to move with it, and however -- whichever direction your wrist winds up moving to get it to move, that's what you got to do, so you can move it -- I mean pulling it back, you're going to turn this way a little or you can pull your wrists forward and backward or up and down instead of inch and out. Sometimes you move them in and out, and sometimes you're moving them forward and backward. It's just whatever the situation calls for at the time." Petitioner testified that he works 8 to 16 hour shifts, and would have two 15 minute breaks and a half hour lunch break. He testified he would work an average of 50-60 hours per week.

The Arbitrator reviewed the job videos submitted by Respondent (Rx4). The T500 Bullet adjuster job involves multiple tasks involving the upper extremities. The extrusion press operator job involves essentially painting a billet, pushing it into the machine with a handle, and otherwise performing quality control tasks. It does appear to be a more repetitive type of task doing the same thing over and over versus the T500 job, which involves more varied tasks. (Rx4).

In October or November of 2014, Petitioner testified he started noticing pain and numbness in his hands and elbows. He testified he reported it to supervisor Brian Huff approximately a week or two before the 2014 Thanksgiving holiday, and about 3 to 4 weeks into performing the extruder job. He reported two to three weeks of numbness into his hands. He saw the on-site medical and was told he would need to seek treatment. He ended up being laid off by Respondent a couple days prior to Thanksgiving, on or about 11/26/14. He testified it might have been the day after he spoke to Mr. Huff. Petitioner acknowledged that he was aware of a layoff coming prior to Thanksgiving, approximately a few weeks into the job as an extruder press operator. He didn't recall discussing workers' compensation benefits with Mr. Huff, or if he indicated to the company clinic that he was capable of continuing to work regular duty or not.

Petitioner testified that he was initially sent by the supervisor Respondent's medical department, who then referred Petitioner for physical therapy at Alton PT, which began on or about 1/19/15 and lasted for about a month. He also had bracing and splints, but he indicated none of this conservative care really helped him. Petitioner testified he had no problems with diabetes, thyroid or rheumatoid arthritis. He also testified to no prior neck, wrist or elbow injuries.

Petitioner agreed he filed an Application for Adjustment in early 12/14 alleging bilateral carpal tunnel (CTS) and epicondylitis. He testified that he had only been to the company injury clinic at that point, and had no diagnosis yet, so he was making an assumption, noting it was based on "what I've heard from other employees that have had it", including "some of the symptoms and how it feels."

When Petitioner sought legal representation and indicated he had not visited any doctors of his own choosing, his attorney recommended that he see Dr. Solman, who became his treating physician. Petitioner testified he initially saw Dr. Solman as an independent medical examiner.

Dr. Solman's 3/20/15 report notes complaints of 18 months of intermittent tingling and pain in the hands and elbows, especially at night, mostly in a median distribution and occasionally in an ulnar distribution. He also indicated some lateral elbow pain. Petitioner reported a 10 year history of working for Respondent as a mechanic, using small tools and lifting lead and brass, and reported that during an 8 hour shift he would lift 138 billets weighing 150 pounds each. Since his November 2014 layoff, "he is occasionally better in terms of his pain but still is painful and has numbness and tingling with basic daily activities." He had previously been hypertensive but no longer needed medication after losing weight. Dr. Solman noted the physical therapy records indicated Petitioner would get temporary benefit with stretches, but no real pain or numbness relief, and Petitioner indicated he didn't know how he would feel if and when he returned to work. Examination noted tenderness to palpation of the lateral epicondyle, some pain with resisted wrist extension, positive Tinel's at the wrist and elbow, positive Phalen's at the wrist, and mildly positive elbow flexion test bilaterally. Dr. Solman diagnosed bilateral lateral epicondylitis, cubital and carpal tunnel syndromes. He opined that Petitioner's work duties were a substantial contributing factor in the development of these conditions, noting minimal systemic problems and no outside activities which would increase the risk of these conditions. He noted that Petitioner reported onset while doing his mechanic job, but that it became more severe when he moved to the extrusion press, prompting him to seek treatment. EMG/NCV was recommended, along with ongoing home exercises. (Px2).

Petitioner testified he would not dispute Dr. Solman's records if they reflected he reported symptoms for approximately 18 months. He testified that, in his mind, he first believed his condition might be related to his job "probably a week after I started doing the constant pushing and pulling of the extrusion press." Asked if he thought his job as an adjuster could have caused the condition, Petitioner testified: "it started with the constant small manipulation of the mechanical side of the adjuster job, but it was exacerbated by the constant use of the extruder job." Petitioner agreed he told Dr. Solman that his symptoms continued after his lay off from work in November 2014.

There is a 5/28/15 Work Status Report from Dr. Solman which restricts Petitioner's work activities to no lifting over 15-20 pounds, no push/pulling over 40-50 pounds, and no repetitive arm motions greater than 10-15 times per hour bilaterally. There is no associated progress note for this date. (Px2). Petitioner testified that the Respondent accommodated the restrictions. He agreed Dr. Solman didn't prescribe surgery or indicate any need for work restrictions on 3/20/15, but testified there was no need for restrictions since he was laid off at the time.

On 6/10/15, Dr. Hurford obtained EMG/NCV testing. Her report notes Petitioner indicated varying degrees of numbness in all fingers of both hands. She reported the EMG/NCV showed mild CTS bilaterally, and no evidence of cubital tunnel or peripheral neuropathy. (Px2).

On 9/8/15, Dr. Solman issued a report that appears to have been in response to a letter from Petitioner's attorney. This indicates that he had recommended EMG/NCV, but also that he believed Petitioner would benefit from surgeries regarding the diagnosed pathologies. It does not indicate that he had yet reviewed the EMG/NCV results.

Currently, Petitioner testified that his elbows hurt constantly. He gets tingling and numbness in his hands and all 5 digits. Sometimes he will awaken with his hands painful and asleep. He testified he had no hand or wrist problems prior to working for the Respondent. Petitioner testified he was recalled to return to work for Respondent as a center cap operator as of 6/30/15, and agreed he was able to do that job without restrictions. He was then moved back to the extruder press operator on 9/3/15, and he performed that job without restrictions, but did use wrist braces. The Petitioner testified the Respondent continued to accommodate his restrictions, working as a "certified charger", noting the job has been modified to essentially be quality control so he stays busy within his restrictions. He has never tried fully performing this job on an unrestricted basis, as it involves constant flexing, pushing and pulling.

On cross examination, Petitioner testified he lifted weights 3 to 4 days per week for about a year while he also worked for Respondent on the T500 machine, and that this included bench presses and curls which involved significantly more than the force used to do his job and more extension and flexion of the elbows. He testified that when he moved to the extruder job in 9/14 or 10/14, it was more physical and would wear him out more, so he stopped lifting weights. He owns a variety of guns and continues to target shoot approximately once a month, but indicated he had no other hobbies involving significant hand or arm use.

Orthopedic surgeon Dr. Solman testified via deposition on 10/27/15. His primary focus is the shoulder and the knee, but he testified he sees several carpal and cubital tunnel patients weekly. Petitioner provided Dr. Solman a history of his job activities, as noted in his report, which Dr. Solman described as repetitive: "The most notable thing was, again, he had been working there for eleven years. After ten years he actually switched jobs and it appeared that his job became a bit more labor-intensive with his hands following that." Dr. Solman also took into consideration the amount of weight that Petitioner had to lift and maneuver at his job bilaterally. Petitioner

reported he began to have pain and tingling in the bilateral wrists and elbows starting around November 2014. He is right hand dominant. (Px1).

Dr. Solman testified he saw the Petitioner on 3/20/15 for an examination at the request of his attorney. He noted Petitioner had hypertension and was obese, but had no other known relevant comorbid conditions that are associated with his upper extremity conditions. X-rays were normal. As to the 5/28/15 restrictions he issued, Dr. Solman testified that they would have precluded him from his customary job with Respondent at that time. It appears that his testimony indicates this report was issued following an inquiry from Petitioner's attorney, and that the Petitioner did not visit Dr. Solman in May 2015. (Px1).

Dr. Solman testified he reviewed the 6/10/15 EMG studies performed by Dr. Hurford, which revealed no evidence of cervical radiculopathy, ulnar or cubital tunnel syndrome but was positive for mild bilateral CTS. Dr. Solman diagnosed Petitioner as suffering from bilateral CTS, bilateral cubital tunnel syndrome and bilateral lateral epicondylitis. He noted that the lateral epicondylitis was a clinical diagnosis and would not be reflected with EMG/NCV testing, though MRI testing could be used to determine if there are microscopic or more significant tears or buildup of scar tissue. He continued to recommend ulnar surgery despite the negative EMG/NCV findings, noting this would depend on ongoing symptoms. He opined that all of these conditions were related to Petitioner's employment. On 9/8/15, Dr. Solman believed he recommended surgery for all of the diagnosed conditions after review of Dr. Hurford's report, and testified he would have continued the work restrictions at that time. (Px1).

On cross-examination, Dr. Solman confirmed that his only knowledge of Petitioner's job duties came from the Petitioner himself. He testified he did not know what a billet was or how a billet was extruded. His understanding is Petitioner developed symptoms working as a mechanic, and that they "at least worsened a little bit" when he moved to the extruder, which Petitioner reported to be more labor-intensive. He agreed Petitioner did not report the conditions to Respondent until he was about to be laid off. Petitioner reported some pain improvement after his layoff, but ongoing pain and numbness. Dr. Solman confirmed that obesity and smoking are non-occupational risk factors for the development of peripheral neuropathy. He agreed he didn't prescribe specific treatment at the initial visit because he first wanted to review the EMG/NCV studies, and did not indicate any work restrictions. Dr. Solman could not recall what prompted him to issue work restrictions on 5/28/15, as he did not see the Petitioner at that time. Petitioner's attorney indicated he may have inquired about restrictions, and Dr. Solman testified: "So the date is probably just an honest date based on when I did the report, but it most likely would have pertained to when I actually examined him." Dr. Solman agreed that individuals who report 1 out of 10 pain would not be limited at work, but could be limited if the work duties increased the pain level. He acknowledged that he was speculating when imposing restrictions in May 2015, and "was trying to protect him if he did eventually go back so that he didn't go back and flare it up worse." (Px1).

Dr. Solman agreed Dr. Hurford indicated negative Tinel's exam findings for the ulnar and median nerves, and could not explain why the findings from Dr. Hurford's physical examination differed from his own findings. As lateral epicondylitis is consistent with inflammation, Dr. Solman agreed he would expect the condition to improve if there was less use of the hands and arms, and it was likely this was improved when Petitioner saw Dr. Hurford. He was not certain when he reviewed the EMG/NCV studies, other than "they're thrown in front of me as I go through my busy day and I read it, look at it, check it off and move on." While he continued to recommend surgery in his 9/8/15 note, Dr. Solman testified that he would need to see the Petitioner again prior to scheduling surgery. Dr. Solman agreed he wanted EMG/NCV studies to provide further information to evaluate surgery, but that a condition with negative findings could still involve a surgical recommendation based on symptoms and clinical findings. (Px1).

Dr. Solman confirmed the $600.00 charges for his 3/20/15 examination were in line with an independent examination, not a normal initial treating visit. He confirmed there was a $50.00 charge for the 9/8/15 report, although it was not associated with an evaluation. (Px1).

Dr. Solman issued his last report on 2/17/16, which appears to be the second time he saw and examined the Petitioner, and which post-dates his deposition testimony. Petitioner reported that over the prior 6 to 8 months he had "a few job changes", noting he went to a job where he just had to push buttons and that he did very well with that with less pain until the job was eliminated. He went back to the extrusion press job and then a job "that is very labor intensive in terms of having to tightly grip the block and put force on the material to thin it out before it gets punched down into the casings." Petitioner felt this job is worse than the extrusion job and requested light duty restrictions so that he could avoid that particular activity. His diagnoses and recommendations remained the same, indicating he would plan to perform surgeries on the left first and then on the right. Dr. Solman restricted Petitioner to no lifting, pushing or pulling over 25 pounds, and no extensive use of the wrists and hands more than 5 to 10 times per hour, noting "these restrictions would certainly preclude him from performing the duties that he has been performing with the large block and smoothing out primer material." This report does not contain any information or opinions in anticipation of litigation that really differ from the prior reports and the deposition, and so the report was admitted by the Arbitrator over the Respondent's objection. (Px2).

As to his 2/17/16 visit with Dr. Solman, Petitioner agreed they discussed the job he was going back to and what he would be doing, and "we decided that the restrictions would be best for my situation." Petitioner testified he continued working because he needed the income for his family, but did agree he had health insurance coverage he could have sought surgery through, and that Respondent also offered 8 weeks of TTD had he sought to put the surgery under group health.

Orthopedic surgeon Dr. Strecker's deposition was taken on 9/22/16. He testified he specializes in the treatment of the hands and upper extremities, and examined Petitioner at the Respondent's request on 10/27/15. Petitioner reported his symptoms gradually developed in approximately November 2014. This involved pain over the bilateral elbow tips, right greater than left, and numbness and tingling involving all of his fingers. He noted that physical therapy had not helped. Petitioner reported his first 10 years with Respondent was as a mechanic, where he would have to lift and carry lead, use air vibrating tools and wrenches daily. The last 6 months he was an extrusion press operator, where he had to lift 100 pound pieces of lead 134 times per day. Dr. Strecker also reviewed job videos (Rx4), testifying: "The video pretty much confirmed what [Petitioner] told me in discussion." Petitioner had been laid off for several months before being back at work for 3 months prior to the 10/27/15 visit. (Rx1).

Dr. Strecker characterized Petitioner as obese or borderline morbidly obese, and noted he was a smoker. He opined carpal tunnel syndrome is associated with comorbid factors of both smoking and obesity. Dr. Strecker's physical exam of Petitioner revealed positive Phalen's and Tinels at the wrists, tenderness laterally in the "soft spots" at the elbows, minimal tenderness over the lateral and medial epicondyles. In regard to the left elbow Dr. Strecker again found tenderness over the soft spot, but did not find tenderness over the epicondyles. He noted a questionable Tinel's sign at the left elbow. There was some reduced range of motion on the left, normal on the right. , which he explained what he meant with "questionable Tinel's" on physical examination of the elbows. (RX 1 at 9). Dr. Strecker noted that Dr. Hurford's exam findings were not consistent with carpal or cubital tunnel. Her EMG/NCV testing suggested mild bilateral CTS, but no evidence of cubital tunnel. (Rx1).

Dr. Strecker diagnosed bilateral CTS and elbow synovitis or irritation, noting these diagnoses were more in common with Dr. Hurford's diagnosis than Dr. Solman's. Dr. Strecker also opined that, given the mild CTS

findings, conservative treatment - such as splinting, NSAIDs, Vitamin B6 and/or steroid injections – should be attempted before determining if bilateral CTS release surgeries were indicated. However, he agreed that if these measures failed, Petitioner would be a bilateral CTS release candidate. He also opined that Petitioner's work activities with Respondent would be a causative factor in the development of CTS, as well as the mild elbow synovitis. No surgery was required for the elbow synovitis. Dr. Solman testified that Petitioner was performing his regular job when he examined him, and that he believed he was capable of continuing to do so. (Rx1).

Dr. Strecker testified on cross examination that the Petitioner did not have cubital tunnel or lateral epicondylitis in his opinion. While he agreed that continuing the same work duties could worsen the elbow synovitis, Dr. Strecker testified that the activities he performed would not have caused cubital tunnel. He testified that while CTS is associated with force and repetition, cubital tunnel is associated with direct trauma or pressure on the ulnar nerve at the elbow, or prolonged hyperflexion. The "soft spot" is part of the outer elbow, while the ulnar nerve sits on the opposite side of the elbow. As such, Dr. Strecker testified that while it is possible that the synovitis could impact or irritate the ulnar nerve, it would not be common and he could not testify to same within a reasonable degree of medical certainty. He also testified that ulnar nerve symptoms can be transient, and such transient symptoms can come from anywhere along the ulnar nerve. Dr. Strecker agreed that the testing performed to date as recommended by Dr. Solman was reasonable and necessary to work the Petitioner up for his symptoms. (Rx1).

Petitioner agreed he told Dr. Strecker he started having symptoms in April 2014 while working as an adjuster, and thought it was from constant fine manipulation motions in that job. Petitioner agreed he has not undergone any form of conservative treatment since seeing Dr. Strecker.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (D), WHAT WAS THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has sustained his burden of proof that he sustained accidental injuries arising out of and in the course of his employment with the Respondent on 11/26/14.

With regard to an allegation of repetitive trauma injury, such as in this case, issues regarding the "arising out of" component of accident and issues of causal connection are intertwined.

Both Dr. Solman and Dr. Strecker have opined that the Petitioner's work duties were a competent cause of Petitioner's bilateral carpal tunnel condition. This is based on both the force/weight involved in the work duties as well as the repetitive nature of the duties. The Petitioner credibly testified to his work duties, and the Arbitrator notes that the video evidence of the job duties was significantly consistent with his testimony. The Petitioner's job, particularly with the extrusion machine, involved an assembly-line type process which was sufficiently repetitive under the Act. The Arbitrator notes that it was this job that the Petitioner testified caused a worsening of the upper extremity condition(s) he developed while working as an adjuster.

With regard to the date of accident, in a repetitive trauma claim such date is the manifestation date, i.e. the date upon which both the nature of the condition(s) of ill-being and its causal relationship to the work duties would

be plainly apparent to the reasonable person. *Peoria County Belwood Nursing Home v. Industrial Comm'n.*, 115 Ill. 2d 524, 505 N.E.2d 1026 (1987). The manifestation date applies to any reasonable person, not to a reasonable physician. *General Electric Corp. v. Industrial Comm'n.*, 190 Ill. App. 3d 847, 546 N.E.2d 987 (1989).

However, in *Durand v. Industrial Comm'n.*, 224 Ill.2d 53, 862 N.E.2d 918, 308 Ill.Dec. 715 (2006), the Supreme Court stated: "We decline to penalize an employee who diligently worked through progressive pain until it affected her ability to work and required medical treatment."

Here, it is fair to say that while the Petitioner certainly suspected that his upper extremity symptoms were related to his employment. However, he did not seek treatment until his job changed and he began working as an extruder operator, which he testified caused a significant increase in his symptoms, significant enough that he reported it to his supervisor, Mr. Huff.

The Respondent raises an issue with regard to the fact that the Petitioner was aware he was going to be laid off, and that is what precipitated his report of the injury. The Arbitrator acknowledges this possibility, but that it is also true that the Petitioner had just had the noted job change. The Arbitrator believes the Petitioner credibly testified that his symptoms increased with the job change, and notes that the statement of the Court in *Durand* would seem to indicate that even if the Petitioner reported the condition subsequent to his lay off, so long as he was able to prove the other elements of his claim, the case could still be found compensable. Therefore, the Arbitrator does not find the timing of the report versus the layoff to be significant to the issues in this case.

The Arbitrator finds in this case that the proper manifestation date is 11/26/14, his last date of employment prior to seeking medical treatment.

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

The Petitioner testified that he notified Mr. Huff of his upper extremity conditions prior to being laid off on 11/26/14. As such, he provided such notice prior to the manifestation date, which would clearly be within the required 45 day period. As such, the Arbitrator finds that the Petitioner provided sufficient notice of his injuries within the period required by Section 6(c) of the Act.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner's conditions of ill-being, consisting of bilateral carpal tunnel and elbow synovitis, are causally related to the 11/26/14 accident.

As noted above, both Dr. Solman and Dr. Strecker opined that the carpal tunnel conditions were causally related to the Petitioner's job duties. The Petitioner only need prove that the job duties were a cause of the applicable conditions, as opposed to proving that they are the primary or most significant cause. As such, the Petitioner has fulfilled his burden of proof with regard to the causal connection of his bilateral CTS conditions.

However, while both of the main physicians in this case, Solman and Strecker, agree that the Petitioner has bilateral CTS, they disagree with regard to the other diagnoses. Dr. Solman has diagnosed bilateral cubital tunnel and lateral epicondylitis in addition to CTS. Dr. Strecker has diagnosed bilateral elbow synovitis, and

specifically has opined that the evidence does not support the Petitioner having diagnoses of cubital tunnel or lateral epicondylitis.

The Arbitrator finds that the greater weight of the evidence in this case supports the finding that the Petitioner has bilateral elbow synovitis, but has failed to prove that he has bilateral cubital tunnel or lateral epicondylitis.

First, the Arbitrator notes that EMG/NCV testing did not disclose conditions of cubital tunnel. While such a finding is not necessarily required given that the diagnosis can be made clinically, in this case both Dr. Strecker and Dr. Hurford indicated that their examinations of the Petitioner did not reflect findings of cubital tunnel. Given these findings along with the negative EMG/NCV testing, the Arbitrator finds that the Petitioner has failed to prove that he has the condition(s) of cubital tunnel syndrome. Given the failure to prove that the condition itself exists, the issue of causal connection is moot.

With regard to lateral epicondylitis, the Arbitrator acknowledges that the condition appears to be made solely on a clinical basis, as such condition would not be determinable via EMG/NCV testing. The Arbitrator notes the findings above with regard to cubital tunnel, as well as the fact that Dr. Strecker appears to have a more defined specialization with regard to the upper extremities other than the shoulder, the Arbitrator finds his testimony to be more credible than that of Dr. Solman with regard to the determination of a diagnosis of Petitioner's elbow condition. Thus, the Arbitrator finds that the Petitioner has failed to prove that he has lateral epicondylitis, but has proven that he has bilateral elbow synovitis conditions which are causally related to his work activities, per Dr. Strecker.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The medical services provided to Petitioner to date have been reasonable and necessary to address his upper extremity symptoms. Dr. Strecker has opined that the treatment to date has been reasonable. As such, the Arbitrator finds that the medical expenses claimed by Petitioner and contained in Px4 and Px5 shall be paid by Respondent.

However, there is one exception, and that is the $940.00 charge Petitioner incurred as a result of the 3/20/15 independent examination of Dr. Solman. While the Arbitrator agrees that Dr. Solman is the Petitioner's treating physician, this initial visit was clearly an independent examination, and Dr. Solman testified that his charges reflected this, and were more costly than his charges would have been for a regular medical visit. As such, the Respondent is not responsible for the initial 3/20/15 examination expenses.

The parties have stipulated that the Respondent is entitled to credit for any of the awarded expenses that were paid by Respondent prior to hearing pursuant to Sections 8(a), 8(j) and 8.2 of the Act, and with regard to such credits, the Respondent shall hold the Petitioner harmless from any claims for payment or reimbursement.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that, based on the testimony of both Dr. Solman and Dr. Strecker, the determination of the reasonableness and necessity of bilateral carpal tunnel surgery is premature. Dr. Solman has opined that he would need to see the Petitioner for an updated evaluation before he could determine if bilateral CTS surgery

would be needed. Dr. Strecker has opined that further conservative treatment, as noted in the findings of fact in this decision, should be attempted before determining whether CTS surgeries are needed. As such, the Arbitrator declines to make a determination of the reasonableness and necessity of such surgeries at this time.

The Arbitrator does note, however, that both doctors have already concluded that the Petitioner does, in fact, have bilateral CTS, and that the conditions are at least in part due to the Petitioner's work activities. The Arbitrator further notes that the Petitioner has had conservative treatment in the form of bracing and physical therapy in the past with no improvement. Therefore, the reasonable determination in this case, from the Arbitrator's perspective, would be to return the Petitioner for an evaluation with Dr. Solman, and to abide by his determination at that time of whether Petitioner requires CTS surgery or surgeries.

As noted above, the Arbitrator has determined that the Petitioner has failed to prove that he has cubital tunnel or lateral epicondylitis, and therefore the proposed surgeries for these conditions are denied. The Arbitrator has determined that bilateral elbow synovitis is causally related to the employment, but that Dr. Strecker has credibly opined that surgery is not an option for this condition. As such, no specific prospective treatment is awarded.

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

Elena Martinez,

Petitioner,

vs.

NO: 08WC 19189

18IWCC0444

Metro Staff 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, 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 November 13, 2017 is hereby affirmed and adopted.

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

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

18IWCC0444

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: JUL 17 2018
SJM/sj
o-6/28/18
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTINEZ, ELENA
Employee/Petitioner

Case# **08WC019189**

METRO STAFF INC
Employer/Respondent

18IWCC0444

On 11/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.30% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
DAVID Z FEUER
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
THOMAS P CRONIN
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

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

Elena Martinez
Employee/Petitioner

v.

Metro Staff, Inc.
Employer/Respondent

Case # **08** WC **19189**

18IWCC0444

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine M. Ory**, Arbitrator of the Commission, in the city of **New Lenox**, on **February 14, 2017 and May 8, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 8, 2009,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$9,470.24**; the average weekly wage was **$182.12**.

On the date of accident, Petitioner was **22** 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.

To date, Respondent has paid **$3,058.06** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of **$3,058.06**for TTD/maintenance, and **$0** for other benefits, for a total credit of **$3,58.06**.

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

ORDER

Temporary Total Disability

Respondent to pay TTD benefits for the period **from February 9, 2008 through February 19, 2008 and February 23, 2008 through May 15, 2008, or 13-3/7 weeks at $182.12 per week**, with credit to be given to respondent for all payments made.

Medical Benefits

The claim for outstanding medical bills is denied.

Permanent Disability

Respondent shall pay Petitioner the sum of **$182.12/week** for a further period of **17.2** weeks, as provided in Section **8 (e) 12** of the Act, because the injuries sustained caused disability to the extent of **3% loss of use of the right leg and 5% loss of use of the left leg.**

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

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

Christine M Ory

Signature of Arbitrator

November 10, 2017

Date

ICArbDec p. 2

18IWCC0444

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elena Martinez	)	
Petitioner,	)	
vs.	)	**No. 08 WC 19189**
Metro Staff Inc.,	)	
Respondent.	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox on February 14, 2017 and May 8, 2017. The parties agree that on February 8, 2009, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act, that their relationship was one of employee and employer, that petitioner suffered accidental injuries that arose out of and in the course of her employment with respondent. They agree that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $9,470.24, and that her average weekly wage was $182.12.

At issue in this hearing was as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether respondent is liable for the unpaid medical bills.
3. Whether temporary total disability is due.
4. The nature and extent of injury.

FINDING OF FACTS

The Petitioner does not speak English; her native language is Spanish. She testified with the assistance of Carmen Kenney, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Ms. Kenney served as an interpreter for the Petitioner.

Petitioner testified that on February 8, 2008, petitioner was packing products. The petitioner packed product into small boxes. She did many of them all day long. Prior to February 8, 2008, petitioner was in good health. Petitioner testified that on February 8, 2008 boxes were coming down the conveyor very fast when the entire conveyor fell on both petitioner's knees; but mostly her left foot. She ended up stretching out both arms to hold up the conveyor.

Petitioner was unable to move her legs; she screamed for help. A co-worker came with a jeep to help move her. Paramedics were called. She testified her entire body had no strength. She was taken to Advocate Christ Hospital/Adventist Midwest Health. She was checked out and returned to work in a wheelchair. As respondent could not accommodate her working in a wheelchair, she was sent home in a cab.

Petitioner returned to the Adventist Midwest Health and was given therapy three times a week for approximately a month. As she did not have money for gas [to continue treating at Adventist

Midwest Health] she sought out treatment for Marquis Medicos. She had pain in her shoulders and back; her leg was very swollen and also her heels, mostly on the left.

She was first seen at Marquis Medicos on July 24, 2008. Her pain from the day of accident until July 24, 2008 was only slightly getting better. Petitioner treated at Marquis Medicos through October 22, 2009. Treatment included medication, an MRI, X-rays, tests and injections into her back.

Petitioner was of work from February 9th through February 19th and again on February 23rd. Petitioner had tried to work, but was unable to continue due to pain. On April 2, 2009, petitioner underwent a functional capacity evaluation at Elite Physical Therapy. She had a repeat functional capacity evaluation at Elite Physical Therapy on September 9, 2009. She was sent for the evaluation by Marquis Medicos. Petitioner was also seen by Dr. John O'Keefe of Marion Orthopedics, who was associated with Marquis Medico.

Petitioner denied receiving any treatment to her arms or legs before the February 8, 2008. She denied having any subsequent accident or injury.

She returned to work for respondent in 2011. She was sent to Gold Standard Baking. It was a sit-down job; working eight hours a day. She closed croissants. She noticed that after a while her shoulder, back and heel bother her. Her foot feels very cold. She had pain going down her left leg. She quit that job after working three years.

She decided to start her own small business making mole sauce. She and her husband run the company. She helps with the cooking, but does no the lifting.

She noticed her back/buttocks hurts late at night when she tries to bend. She takes over the counter medication to alleviate the pain; Motrin and Tylenol.

Petitioner has had no treatment by any doctor since 2009.

Petitioner indicated the conveyor fell on her upper legs; thigh area, just above the knees. Petitioner confirmed the pain was located on the heel of the left foot and left thigh above the knee.

Petitioner a MRI of the lower back on April 8, 2008. She had an EMG done on June 13, 2008.

She saw Dr. Dzwinik on May 15, 2008, October 23, 2008 and May 6, 2010.

Marquis Medicos Records (PX.1)

These records run from January 2, 2009 through November 23, 2009. She was discharged from care on February 19, 2010. Treatment was mainly physical therapy for low back, left knee and left heel pain.

There is also a pain management consultation by Dr. Krishna Chunduri on December 30, 2008. Dr. Chunduri noted minimal myofascial tenderness over the lumbar spine. Petitioner reported considerate pain improvement from injections.

The records include an April 3, 2009 EMG, which was reported as normal.

As of June 12, 2009, petitioner underwent 16 work conditioning sessions and was then downgraded to physical therapy.

The records include orthopedist, Dr. Daniel Ivankovich records whose diagnosis range from low back pain, as well as left knee pain and left heel pain. The diagnosis included plantar fasciitis of the left foot.

Marquis Medico Bills (PX.2)

The medical bills from January 2, 2009 through February 19, 2010 totaled $49,943.00; with a balance due claimed of $33,935.00 (PX.2 a).

The medical bills from July 24, 2008 through August 31, 2009, which included facility fees and prescriptions, totaled $49,015.71 (PX.2 b).

Total physical therapy bills for treatment rendered from March 18, 2008 through December 30. 2008 totaled $56,504.00; with a balance due claimed of $35,533.93 (PX.2 c).

Marian Orthopedic & Rehabilitation Bills (PX. 3)

The total amount for the bills for treatment rendered from April 16, 2008 to through July 22, 2008 is $1,599.00; with a balance due claimed of $1,349.00.

Elite Physical Therapy Records and Bills (PX.4)

Petitioner underwent a functional capacity evaluation on April 3, 2009, and then work conditioning. She had a repeat functional capacity evaluation on September 9, 2009. She reported on September 9, 2009 that she had injured her right knee and right foot. Both functional capacity evaluations were reported as valid and concluded petitioner could not return to her pervious employment.

The claimed bills for treatment rendered totaled $11,072; with a balance claimed due of $9,776.96

Delaware Place MRI Report (RX.1)

A lumbar MRI was performed on April 8, 2008 due to back pain. The MRI was completely negative and reported as unremarkable.

June 13, 2008 EMG/NCV Report (RX.2)

An EMG/NCV was performed on June 13, 2008 due to reported lumbar radiculopathy. It was completely negative.

Dr. Jaroslaw Dzwinyk February 22, 2016 Deposition (RX.5)

Dr. Jaroslaw Dzwinyk, board certified orthopedic surgeon, testified in behalf of respondent. Dr. Dzwinyk examined first examine petitioner on May 15, 2008 and authored a report of his exam and findings (Dep. Ex.#2). Dr. Dzwinyk's diagnosis was contusions of both thighs (21). Dr. Dzwinyk did not find the neck and lower back claimed conditions were related to the work accident (22). Dr. Dzwinyk believed petitioner had reached maximum medical improvement at the time of his May 15, 2008 exam (23). Dr. Dzwinyk believed petitioner could return to full duty work with six to eight weeks of the accident; or March 21, 2008 (23).

Dr. Dzwinyk re-examined petitioner on October 23, 2008 and authored a report (Dep. Ex. #3). At the time of the October 23, 2008, petitioner reported her lower back, neck and left shoulder pain had resolved; with her main complaints in her left thigh, left leg and most severe in left ankle and heel (24). Dr. Dzwinyk believed the ongoing treatment to her neck and back was unrelated to the claimed work injury (24-25).

Dr. Dzwinyk viewed a video tape of petitioner doing daily activities May 16, 2008 through September 1, 2008 and authored an addendum report on October 30, 2008 (Dep. Ex. # 4). At the time of Dr. Dzwinyk found petitioner's activities as depicted on the video tape was different than petitioner's presentation to his office on May 15, 2008, in that petitioner was limping and using a cane when she was in Dr. Dzwinyk's office and not on the video (28-29).

Petitioner was examined by Dr. Dzwinyk for a third time on May 6, 2010 and authored a report (Dep. Ex.#5). At the time of this exam, petitioner's complaints were to her left ankle and

heel (30). Petitioner's examination was completely normal with only tenderness in the back of the ankle (31). Dr. Dzwinyk could not find any objective basis to make a diagnosis of petitioner's ongoing complaints in the left ankle and heel (33). Specifically, Dr. Dzwinyk did not believe there was any causal connection between the February 8, 2008 and the later diagnosis of plantar fasciitis of petitioner's left heel, as well as her left knee complaints (33-34).

Dr. Dzwinyk agreed with utilization review that determined the appropriate amount of therapy treatments and chiropractic visits were twelve each (35).

Dr. Allan Brecher September 27, 2016 Deposition (RX.6)

Dr. Allan Brecher, board certified orthopedic surgeon testified in behalf of respondent. He performed a utilization review through Network Medical Review and authored a report dated August 20, 2009 (Dep. Ex. #2). Dr. Brecher did not certify the steroid injections performed (10). He certified the first EMG, but not the second (11). After reviewing the medical records, including the reports of Dr. Dzwinyk, Dr. Brecher certified twelve physical therapy visits and twelve chiropractic visits (17-18).

Adventist Midwest Health Status February 8, 2008 Report (RX.8)

On the day of the occurrence, the diagnosis was right thigh contusion and abrasion; whereas the diagram showed the left thigh.

Adventist Bolingbrook Occupational Health Records (RX. 9).

On March 3, 2008 the history was a blow to the left greater than right thigh. The diagnosis was thigh contusion.

On March 10, 2008 her complaints were centered to the left thigh. She was referred to Hinsdale Orthopedics due to ongoing thigh pain.

CONCLUSIONS OF LAW

F. With respect to the issue regarding whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following finding:

Petitioner sustained contusions to both her left and right thigh; left greater than right. Furthermore, the Arbitrator finds the contusions to her thighs had resolved by the time of her exam by Dr. Dzwinyk on May 15, 2008.

There was no evidence petitioner had injured any other body parts. Specifically, the Arbitrator finds petitioner's complaints of pain to her neck, lower back, left knee, left ankle or left heel are unrelated to the claimed work accident.

Therefore, the Arbitrator finds petitioner's claimed condition of ill-being involving her neck, lower back, left heel and left ankle were not caused by the accident of February 6, 2008.

J. With respect to the issue regarding medical bills incurred, the Arbitrator finds the following:

The Arbitrator finds that the claimed medical bills for ongoing medical treatment were not related to the work accident. The Arbitrator further finds that any treatment after May 15, 2018 was not reasonable or necessary.

The Arbitrator, therefore, denies the claim for the outstanding medical bills.

K. With respect to the issue regarding temporary benefits, the Arbitrator finds the following:

The evidence supports a finding that petitioner was disabled from February 9, 2008 through February 19, 2008 and February 23, 2008 through May 15, 2008. The Arbitrator awards temporary total disability benefits for this period of disability, which is 13-3/7 weeks at the rate of $182.12 per week.

L. With respect to the issue regarding the nature and extent of injury, the Arbitrator finds the following:

The Arbitrator finds petitioner sustained contusions to both thighs, with residual pain to both thighs, worse on the left and awards 3% loss of use of the right leg and 5% loss of use of the left leg, pursuant to §8 (e) 12, which is 17.2 weeks at the permanent partial disability rate of $182.12 per week.

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

Luz Maria Ruiz Mendez,

Petitioner,

vs. NO: 16WC028517

Labor Network,

18IWCC0445

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, 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 November 6, 2017 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.

JUL 17 2018

DATED:
SJM/sj
o-6/28/18
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

RUIZ MENDEZ, LUZ MARIA
Employee/Petitioner

Case# **16WC028517**

LABOR NETWORK
Employer/Respondent

18IWCC0445

On 11/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
JASON BRISKI
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

5001 GAIDO & FINTZEN
JASON ALLAIN
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)SS.

COUNTY OF Cook)

18IWCC0445

- [ ] 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)

Luz Maria Ruiz Mendez
Employee/Petitioner

v.

Labor Network
Employer/Respondent

Case # **16** WC **28517**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **August 28, 2017 and October 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

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

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

G. [x] What were Petitioner's earnings?

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

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

J. [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. [x] Other **Dependency, Chain of Referral 8(a)3**

FINDINGS

On the date of accident, **3/29/16**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**18,498.77**; the average weekly wage was $**355.75**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **3** dependent children.

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

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

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

ORDER

Petitioner did not prove that she sustained accidental injuries arising out of and occurring in the course, of the employment on March 29, 2016.

Compensation, prior medical, and prospective medical are denied.

See Arbitration Decision 19(b) in consolidated case 16 WC 28515 for findings of fact and conclusions of law.

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

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

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

David A. Kane
Signature of Arbitrator

November 6, 2017
Date

ICArbDec19(b)

NOV 6 - 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☐ 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

Thomas Hanks,

Petitioner,

vs.

NO: 15 WC 3593

18IWCC0446

Metro East Industries, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice provided to all parties, the Commission after considering the issues of causal relationship, medical expenses both incurred and prospective, and being advised of the facts and the law, vacates the Arbitrator's conclusions of law as stated below, and modifies the Decision of the Arbitrator which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of an amount of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

CONCLUSIONS OF LAW

The Commission finds the Petitioner failed to prove a causal relationship between his accident of February 7, 2012 and his current condition of ill-being and need for treatment. "[T]he Commission is not bound by the arbitrator's findings and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. [citation omitted]." *R.A. Cullinan and Sons v. The Industrial Commission*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240 (1991). The "interpretation of the testimony of medical witnesses is particularly within the province of the Industrial Commission. [citation omitted]." *A.O. Smith*

Corporation v. The Industrial Commission, 51 Ill. 2d 533, 537, 283 N.E.2d 875 (1972). The Commission modifies the Arbitrator's decision and finds Petitioner reached maximum medical improvement on February 20, 2012 and failed to prove a causal relationship for his current condition of ill-being thereafter based upon the opinions of Dr. deGrange.

The Commission weighs the competing medical opinions of Dr. deGrange and Dr. Raskas and affords greater weight to the opinions of Dr. deGrange finding such opinions more persuasive. Moreover, Dr. deGrange's opinions are supported by the opinions and findings of Dr. Wayne.

Petitioner testified at trial he sustained injury on February 7, 2012 when a piece of steel struck him on the back of his head thereafter landing on his back and legs. T. 18. Petitioner testified immediately following the accident, he mainly felt pain in the lower back, left hip and into his legs. T. 19.

The medical records evidence Petitioner sought treatment on February 7, 2012 from Memorial Hospital emergency room. PX1. Petitioner provided a consistent history of injury with complaints of pain to his ankle and hip as well as back pain. There is no mention of neck or shoulder pain. X-rays were performed of the pelvis/hip, lumbar spine, and left ankle as well as a CT scan of the abdomen. No diagnostic testing was performed regarding Petitioner's cervical spine or shoulder. *Id.*

The medical records evidence Petitioner sought treatment from Midwest Occupational Medicine from P.A. Andrew Colon. PX2. On February 9, 2012, Petitioner provided a history of injury as follows: "the patient was struck by a piece of heavy sheet metal that fell onto his left back causing to crumple over" with the following pain complaints: "primarily his pain is in his left flank and left groin area. He also complains of pain in his left foot." *Id.* Petitioner was evaluated on February 13, 2012 and February 16, 2012 with a diagnosis of a contusion of the left flank, upper buttocks and upper left thigh. At Petitioner's insistence, he is released to return to work full duty during his February 20, 2012 evaluation. Of note the records of this visit memorialize the following: "He suffered significant contusions to his left flank, upper left buttock and upper left thigh…He has no other complaints at this time." PX2.

Petitioner returned to work full duty and worked without incident until January 28, 2014, a span of nearly two years. T. 22. Petitioner testified he felt pain in his back and shoulder blades during this time. *Id.* Again, though, Petitioner worked a heavy job and sought no treatment.

Dr. deGrange evaluated Petitioner on two occasions pursuant to Section 12 of the Act at Respondent's request, June 16, 2015 and September 6, 2015, respectively. On September 27, 2016, Dr. deGrange provided testimony via evidence deposition. Dr. deGrange testified Petitioner suffered from cervical spine degeneration which bore no causal relationship to the accident of February 7, 2012. RX1, p.21. Dr. deGrange personally reviewed a cervical MRI obtained on February 28, 2015 and concluded the findings were consistent with cervical

degeneration with no clinically significant abnormal findings. RX1, p. 19. Dr. deGrange explained Petitioner did present with neck complaints during the evaluation, but such complaints were not associated with the February 7, 2012 accident as no contemporaneous medical records documented complaints or injury to the cervical spine. RX1, p. 28.

Dr. deGrange's testimony was supported by the records and testimony of Dr. Wayne. Dr. Wayne evaluated Petitioner on several occasions in 2014. On February 20, 2014, Petitioner provided a history of pain in the mid to lower thoracic region as well as the lumbar region. PX4. Dr. Wayne diagnosed Petitioner with thoracic and lumbar strains as well as chronic thoracic pain. Dr. Wayne evaluated Petitioner on three additional occasions providing trigger point injections in the thoracic and lumbar areas. On April 9, 2014, Dr. Wayne placed Petitioner at maximum medical improvement and continued Petitioner's participation in full duty work. *Id.*

On October 25, 2016 Dr. Wayne provided testimony via evidence deposition. Dr. Wayne testified Petitioner complained of pain in the right upper thoracic and scapular region as well as the lower back. RX2, p. 15. Dr. Wayne testified he did not recommend treatment for Petitioner's cervical spine as Petitioner's complaints did not warrant such treatment. RX2, p. 17.

Certainly, Dr. deGrange's and Dr. Wayne's opinions sit in contrast to those of Dr. Raskas. Petitioner commenced treatment with Dr. Raskas on February 17, 2015 at which time Petitioner continued to complain of intrascapular and periscapular pain but also for the first time, complained of right-sided neck pain and pain radiating into his right shoulder. PX5. After excluding the shoulder as a cause of Petitioner's pain, Dr. Raskas diagnosed cervical problems and recommended a C5-C6 anterior decompression and fusion which he attributed to Petitioner's work injury. *Id.*

Dr. Raskas provided testimony via evidence deposition on July 8, 2016. Dr. Raskas testified Petitioner suffered from a cervical displacement at the C5-C6 level which was caused by the February 8, 2012 accident and aggravated by the January 28, 2014 accident. PX6, p. 12. In arriving at this conclusion, Dr. Raskas based his opinion, in part, on a pain diagram created on a date unknown which evidenced neck pain. PX6, p. 29. Dr. Raskas, in essence, concluded Petitioner's neck pain began after the initial accident and continued unabated leading Dr. Raskas to opinion a causal relationship between the accident and Petitioner's current need for treatment.

As previously stated, the Commission does not find such opinion persuasive as there exists little factual support in either the medical records in and around February 7, 2012 or Petitioner's testimony. An expert's opinion is only as valid as the facts upon which it is based. *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC. Dr. Raskas' opinion is predicated on correlation and not causation which is the appropriate legal standard.

Dr. deGrange's and Dr. Wayne's opinions, in contrast, are supported by both the medical records and testimony. Petitioner suffered an accident on February 7, 2012 requiring him to obtain medical treatment for his thoracic and lumbar spine. After a short course of conservative treatment, Petitioner was placed at maximum medical improvement on February 20, 2012 and returned to full duty work. Petitioner continued to work without incident in a heavy job for almost two years. Petitioner voiced no complaints of cervical and/or neck pain during this period of time nor did he obtain any medical treatment. The first recorded medical history of neck and/or cervical complaints are to Dr. Raskas on February 17, 2015 over three years following the February 12, 2012 accident. As Dr. deGrange opined such complaints are consistent with cervical degenerative disc disease as evidenced by the MRI. Petitioner failed to prove his current condition of ill-being and need for treatment was caused or aggravated by the February 7, 2012 accident.

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981). The same standard applies to prospective medical care. *Homebrite Ace Hardware v. The Industrial Commission*, 351 Ill. App. 3d 333, 814 N.E.2d 126 (2004). Petitioner sustained thoracic and lumbar strains due to his accident of February 7, 2012 with maximum medical improvement being reached by February 20, 2012. As such all treatment following Petitioner's discharge from care on February 20, 2012 is neither reasonable nor necessary nor is it causally related to Petitioner's accident. The Commission vacates the award of medical expenses after February 20, 2012 specifically Professional Imaging in the amount of $4,130.00 and Orthopedic Sports Medicine in the amount of $3,615.00. The Commission notes the arbitrator awarded payment to Dr. Keith Byler in the amount of $1,709.97 pursuant to Petitioner's Exhibit 7 but no corresponding invoice is found in the record. An invoice from Midwest Occupational Medicine evidences a zero balance.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's August 9, 2017 decision is modified for the reasons stated herein.

IT IS FURTHERED ORDERED BY THE COMMISSION that the Respondent pay the medical bills from Memorial Hospital and Midwest Occupational Medicine, if outstanding, pursuant to Section 8(a) and Section 8.2 of the Act.

IT IS FURTHERED ORDERED BY THE COMMISSION that the award of medical expenses to Professional Imaging in the amount of $4,130.00 and Orthopedic Sports Medicine in the amount of $3,615.00 is hereby vacated.

IT IS FURTHERED ORDERED BY THE COMMISSION that the award of prospective medical care is hereby vacated.

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

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

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

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: JUL 18 2018
LEC/maw
o04/10/18
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

HANKS, THOMAS
Employee/Petitioner

Case# **15WC003593**

16WC007393

METRO EAST INDUSTRIES INC
Employer/Respondent

18IWCC0446

On 8/9/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1846 BROWN AND CROUPPEN PC
KERRY I O'SULLIVAN
211 N BROADWAY SUITE 1600
ST LOUIS, MO 63102

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

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

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

THOMAS HANKS
Employee/Petitioner

v.

METRO EAST INDUSTRIES, INC.
Employer/Respondent

Case # **15** WC **03593**

Consolidated cases: **16 WC 07393**

18IWCC0446

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 2, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,381.10**; the average weekly wage was **$890.88**.

On the date of accident, Petitioner was **48** years of age, *married* with **0** dependent children.

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

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

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

ORDER

The Arbitrator finds that the Petitioner's current cervical/thoracic condition is causally related to the February 7, 2012 accident. Any lumbar condition or other condition which resulted from the February 7, 2012 accident was no longer causally related to the accident as of February 20, 2012.

Respondent shall pay reasonable and necessary medical services contained in Petitioner's Exhibit 7 related to the cervical and thoracic spines through the date of hearing, and any other medical expenses related to the February 7, 2012 accident which were incurred through February 20, 2012, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize the C5/6 fusion surgery recommended by Dr. Raskas pursuant to 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

July 31, 2017
Date

AUG 9 - 2017

STATEMENT OF FACTS

Petitioner, a 53 year old married male, testified that he has worked for the Respondent for 20 years. He initially worked as a painter, which most recently involved de-screening rack rail cars, but at the time of hearing he was working light duty for Respondent walking around and picking up trash. To de-screen a rack car, he would use a hammer to knock all the plastic off of the screen and cut the brackets off; when the screen then fell, he would pick it up and put it in a pile. He would knock bolts out with a hammer and use an air ratchet to remove kick panels. Once the screen was removed, then he would rake up all the pieces and put them in the dumpster. Respondent presented video of the job as Respondent's Exhibit 6. The Arbitrator notes that the videos depicted duties significantly consistent with the Petitioner's testimony.

On 2/7/12, Petitioner testified he was de-racking a rack car, which is a train car that hauls vehicles. He had the rack cut and bent down to get his air hose when a forklift driver hit the rack and knocked it off the car. It fell and hit Petitioner across the back of the head and then landed across his back and legs. Petitioner testified that this piece of steel weighed between 1,000 and 1,500 pounds, and that his hard hat and welding hood were broken when he was hit in the head. Co-workers picked the piece of steel up off of him. In an accident report (Rx4) completed by Petitioner, he indicated that "Bob" witnessed the accident, that he was struck "all over" his body, and that "everything" bothered him.

Petitioner went to Memorial Hospital emergency room on the day of the injury. He testified that his primary complaints were to his lower back, left hip and down his legs, primarily the left leg. The 2/7/12 report from Memorial Hospital indicates Petitioner reported "a 1,000 pound piece of steel fell onto his left leg ankle and hip area from a train car", and he complained of the left ankle and hip as well as back pain. A CT scan history notes trauma to the chest and abdomen as well. The abdominal scan showed no acute injury. Bilateral hip x-rays showed mild osteoarthritis with no acute osseous abnormality. Lumbar x-rays were normal with mild disc narrowing at L5/S1. Left ankle x-ray was negative. The Petitioner was ambulatory at discharge and was advised to follow up with Dr. Byler the next morning. (Px1).

On cross examination, Petitioner testified that he has had pain in the low back and between the shoulder blades since this accident occurred.

Petitioner followed up at Midwest Occupational through February. On 2/9/12 he saw Physician's Assistant (PA) Colon, reporting being struck by an approximate 4' x 6' piece of sheet metal on his left back, crumpling him over and causing him to catch his foot and ankle. He complained of general achiness, but primarily pain in his left flank, left groin, left foot. An abrasion 4 x 6 inches long and 3-4 inches wide was noted on his left flank, and there was some tenderness to palpation in the left low back/SI joint area. There was some ecchymosis of the

left foot and pain in it with weightbearing. He was diagnosed with contusions, prescribed medication and given sedentary restrictions. (Px2).

On 2/13/12, PA Colon noted Petitioner had been on sedentary duty since the accident. Petitioner reported he was better but still very much sore with pain in his left flank, upper left buttock and upper left thigh, with healing abrasions from the posterior tenth rib extending down to the iliac crest. He had no numbness or tingling in the extremities. His gait was guarded and he felt Aleve was working better than Vicodin. He was continued on sedentary duties. (Px2). On 2/16/12, Petitioner reported he was feeling better and wanted and was anxious to return to work full time, though he still had pain from the left flank into the buttocks and thigh. Sedentary duty was continued as a precaution, noting this was also explained to Respondent's safety officer. On 2/20/12, Petitioner noted he still had occasional pain, but felt he was recovering well and approaching his normal activity level. Though Dr. Shearling noted it was clear he still had some healing to do to reach 100%, Petitioner was returned to work full duty and advised to return as needed. (Px2).

As to the records indicating Petitioner was eager to return to full duty, he testified that the employer "asked me to work with them so it wouldn't be a long – lost time injury", as well as because he would rather be working than sitting around. He indicated he was able to do his de-screening job in 3.5 hours while still being paid for 10 hours, so "I can go home versus just sitting there all day", and therefore rest his back. He testified that he worked this regular job when he was on sedentary duty before being released to full duty on 2/20/12. He continued to work full duty but testified that his low back continued to hurt as well as the area between his shoulder blades, and that he reported this to Respondent.

On 1/28/14, Petitioner testified he was changing and lifting a 50 to 60 pound propane tank at work, and it "aggravated the injury that's already there" in the low back and between the shoulders. The accident report (Rx5) for this incident has a paucity of information in it, other than Petitioner indicating it "feels like someone is stabbing me in the back." He returned to Midwest Occupational the next day, 1/29/14, reporting that he was reaching overhead in a twisting motion while changing a propane tank and felt discomfort in his lower back. He also reported chronic mid back pain since his 2012 work accident, "but now has the added pain in the lower lumbar region since his twisting injury yesterday." He rated his pain at 2/10 at rest and 5 to 6/10 with motion. Petitioner "attributes a lot of his chronic pain to (the 2012 incident) and believes that this is most of what he is feeling today. There is a minor increase in the pain in the lower back due to the twisting nature of his work from yesterday, but overall most of his pain is his baseline pain that he has been experiencing since 2012. Medical history notes chronic thoracic and low back pain with left sciatica symptoms since the prior 2012 injury. Exam noted some mild tenderness to palpation with some loss of range of motion, and neurological exam was normal. Petitioner was advised to return to work as tolerated and to take Aleve. Dr. Scheidler stated: "We had an extensive discussion that I believe a fair amount of his pain is related to his chronic back pain that he has been having for over a year. I do not know whether this pain is related to arthritis or degenerative disc disease, but based on our discussions, the vast majority of the symptoms he is feeling today, he has felt for the past year. There may be a mild increase in the lumbar back pain that he is feeling today over his baseline, but the rest of his symptoms seem to be relatively chronic in nature." (Px2).

On 2/5/14, Petitioner noted no real improvement and that he "insists on getting to the heart of the problem with regard to his chronic pain." Petitioner was advised by PA Colon that they first needed to address the current incident. Petitioner mentioned going to his prior doctor, and was told that was an option, but he agreed to try physical therapy and to continue working as tolerated. Colon stated: "Since the patient and I did not get off on a good footing, I advised the patient that his follow up will be with Dr. Byler. . ." (Px2).

The 2/10/14 last visit with Midwest Occupational was with Colon, and noted Petitioner was there primarily for MRI review. PA Colon noted a small L4/5 bulge with left paramedian protrusion that could be impacting the left L5 nerve root and causing sciatica. A non-specific L1 left paraaortic mass was also noted for which he was advised to see his family doctor. Colon referred Petitioner to a spine specialist, noting the MRI changes "although minimum . . . may be the cause of his low back pain." (Px2).

Petitioner testified that the Respondent scheduled him to see physiatrist Dr. Wayne. On 2/20/14, Dr. Wayne noted Petitioner reported the 1/28/14 work injury with low back pain radiating into the thoracic area. He also noted occasional numbness in the posterior thighs. Petitioner also reported a history of a crush injury to his thoracic and lumbar spine 1-½ years prior and advised that he had continued to experience pain ever since that time. He indicated his thoracic pain was back to baseline level, but that his low back pain remained worse since the 1/28/14 incident. Dr. Wayne then stated: "Shortly after that, he completely altered his story and stated to me that his thoracic pain is actually currently more severe than his lumbar pain." (Px4).

Dr. Wayne's review of Petitioner's job description indicated it to be a very heavy job which included lifting over 100 pounds at times. Current complaints included an aching pain in the thoracic and lumbar spine with a stabbing pain in the thoracic region several times a day that was so severe he nearly falls down. Based on what appears to be a checklist of review of symptoms, Petitioner indicated neck pain, thoracic pain, low back pain, right arm pain and bilateral leg numbness. Petitioner indicated he was currently working light duty. Examination noted pain in the thoracic and lumbar paraspinals and normal neurological exam. Dr. Wayne diagnosed thoracic and lumbar strains from the last injury, and a history of chronic ongoing back pain since the 2012 injury mainly involving the thoracic spine. Dr. Wayne felt there was no radiculopathy, and opined that it was puzzling whether his pain was from the most recent injury versus the first injury in 2012. Dr. Wayne felt the lumbar and thoracic pain was worse than prior to the most recent injury. Dr. Wayne ordered physical therapy, Flexeril and restricted duty. (Px4).

On 3/13/14, Petitioner told Dr. Wayne his low back pain was significantly better with therapy, but his thoracic pain was not improved. Dr. Wayne indicated persistent mainly thoracic myofascial pain, and prescribed and performed bilateral thoracic trigger point injections. Petitioner reported eagerness to return to his regular work duties, and Dr. Wayne indicated he could do so as of 3/17/14. On 3/27/14, Petitioner reported about a week of relief with the injections before symptoms returned, but that it was more of the deep achy pain with resolution of the stabbing type symptoms. Trigger point injections were performed at the low thoracic and lumbar levels bilaterally, and Dr. Wayne indicated he could return to full duty on 3/29/14. At the last follow up with Dr. Wayne on 4/9/14, Petitioner reported improvement in the left upper thoracic region with soreness in the right upper thoracic and scapular regions along with across the low back. He felt he had moderate relief with the thoracic injections, and no relief with the lumbar shots. Noting Petitioner had quite a bit of overall improvement, but persistent mechanical thoracic and lumbar pain which Petitioner stated was "tolerable", Dr. Wayne released him at maximum medical improvement and indicated he could continue his regular work duties. (Px4).

Petitioner then returned to Dr. Wayne on 1/20/15. The report notes consistent histories of both the 2/7/12 and 1/28/14 incidents, noting Petitioner stated "the pain was essentially the same but it seemed to get worse when he was lifting the heavy tank" on 1/28/14. He denied any new injury, reporting he's continued to have persistent pain in the areas noted on 4/9/14 but had been able to get by at work. He had been switched to a job involving a grinder a month ago and since that time had worsening of the upper to mid thoracic region along with the lumbar area, even radiating into the base of the right neck. Noting it appeared Petitioner had an aggravation of his injuries with the grinding activities, he prescribed medications. Petitioner indicated therapy had not helped him in the past, and Dr. Wayne advised him to avoid using vibratory tools.

Petitioner saw board certified orthopedic surgeon Dr. Raskas in the same office on 2/17/15, which he testified was at the request of the Respondent. Petitioner reported the 2/7/12 incident, indicating he "could not move any of his extremities for many minutes", but was ultimately diagnosed with nothing beyond bruises and was returned to work. He stated he'd had persistent pain since, including the right neck and scapula into the shoulder and upper arm, and over the left posterior pelvis into the buttock with no radiation into the leg. Injections helped. Petitioner reported he was working with restrictions, but didn't know if the employer had any light duty available. Review of lumbar x-rays noted mild degenerative disc disease throughout, most significant from L4 to S1, with no instability. Cervical films demonstrated moderate, age appropriate degenerative changes. Following exam, Dr. Raskas indicated that while Petitioner was being treated for a presumed thoracic problem, he suspected cervical radiculopathy and a possible shoulder problem as well. Cervical, lumbar and right shoulder MRIs were prescribed. (Px5).

Dr. Raskas issued an addendum report on 3/6/15 after reviewing Petitioner's prior medical records, stating: "He does describe pain in the thoracic spine and pain around his shoulder blades as stemming back after the 2012 work injury. (Petitioner) was involved in a fairly severe accident. I believe initially his flank pain and lumbar pain may have been more prominent. As those resolved the mid-back pain, which I believe may be coming from the cervical spine, became more prevalent. His current symptoms are directly attributable to the 2012 work injury." (Px5).

Multiple MRIs were obtained on 2/26/15 as prescribed by Dr. Raskas. Lumbar MRI was read to show mild multilevel internal disc derangement, including disc bulges, and mild facet joint arthropathy. A subtle annular fissure was seen at L4/5. There were no lateralizing protrusions or stenosis. Cervical MRI revealed multilevel internal disc derangement and posterior protrusion most prominent at C5/6, mild C5/6 stenosis relative to other cervical levels, and degenerative encroachment of the nerve root canals at C5/6. Right shoulder films reflected mild supraspinatus and infraspinatus insertional tendinopathy but no tear, AC joint osteoarthritis with low grade sprain, trace subacromial-subdeltoid bursitis and right chest wall edema. (Px3).

Following his review of the MRIs on 3/9/15, Dr. Raskas believed the C5/6 disc protrusion with some bilateral foraminal stenosis could account for his pain, or could be just normal aging changes. He prescribed a diagnostic block at that level with Dr. Hurford, which was performed on the right on 3/24/15. Dr. Raskas also noted right shoulder tendinopathy in the films and recommended he see a shoulder specialist, Dr. Solman. He was otherwise advised to continue with restricted work. (Px5).

On 4/17/15, Petitioner reported to Dr. Raskas that the nerve block did not provide immediate relief, but that he had marked relief the following day, and that "the symptoms even switched sides." Pain then returned and was again back in the right shoulder, and Dr. Raskas noted Petitioner should have the shoulder evaluation with Dr. Solman because he had so many symptoms with shoulder activity. He opined that if Dr. Solman didn't find anything significant with the right shoulder, in all likelihood a C5/6 anterior fusion would be appropriate, and that such surgery would be directly attributable to his work injury. (Px5).

Petitioner saw Dr. Solman on 4/17/15, reporting that the C6 injection significantly improved his neck pain for a few days, and after it wore off he continued to have pain radiating down the right shoulder and arm into the hand. Following exam and review of a shoulder x-ray, Dr. Solman opined Petitioner did not have a surgical problem in the right shoulder, diagnosing cervical pathology and mild right shoulder biceps tendonitis. It is clear he did not realize an MRI of the shoulder had previously been obtained, as he indicated he did not believe one was needed. He released Petitioner and advised he continue a cervical work up with Dr. Raskas. (Px5).

On 6/16/15, orthopedic surgeon Dr. deGrange performed the first of two Section 12 exams at Respondent's request. Dr. deGrange had available the prior medical records as well as the MRI of the cervical spine. Dr. deGrange opined that there was no cervical injury as a result of the 2/7/12 work accident and that his current complaints and treatment recommendations were not causally connected to the 2/7/12 work accident. Dr. deGrange opined Petitioner could continue with his usual and customary job activities. He opined that irrespective of causation, he did not find there was sufficient correlation between Petitioner's subjective complaints and objective findings indicating the need for surgery. (Rx1).

On 8/11/15, Dr. Raskas sent Petitioner's counsel a letter in which he opined the 2/7/12, work accident caused the C5/6 injury and need for surgery. (Px6). On 12/8/15, Dr. deGrange prepared a supplemental report in which he opined Dr. Raskas' 8/11/15 letter did not impact his opinion on causation. Dr. deGrange cited to the Midwest Occupational records from 2012 that did not show any evidence of a neck injury. (Rx1).

On 1/28/16, Dr. Raskas prepared a second report addressed to Petitioner's attorney. In this report he opined that the 1/28/14 accident was more likely than not a temporary aggravation of the cervical condition that was producing referred pain to the interscapular area. (Px6).

On 9/6/16, Dr. deGrange performed a second examination. Petitioner reported neck pain with bilateral upper extremity pain, tingling and numbness, worse right than left. He reported that the symptoms worsened with work activities, particularly with prolonged or repetitive overhead work and use of vibratory tools. Petitioner acknowledged that there had not been much work recently screening railcars. Dr. deGrange's opinion remained that there was no causal relationship between the 2/7/12 work accident and current cervical condition. He agreed that given Petitioner's persistent symptoms that he would not dispute Dr. Raskas' current recommendation for surgery. (Rx1).

Dr. Raskas was deposed on 7/8/16. (Px6). He had not seen the Petitioner since 4/17/15. He reviewed the report of Dr. Solman, which indicated no surgical problem in the right shoulder, and that his recommendation therefore was C5/6 anterior decompression and fusion. He agreed he issued 8/11/15 and 1/26/16 addendum reports at the request of Petitioner's attorney following a review of additional medical records and reports of Dr. deGrange. He noted an undated pain diagram in the records of Midwest Occupational that appeared to have been from the initial visit there in 2012 wherein Petitioner indicated sharp pain between the shoulder blades, despite this complaint not being mentioned by PA Colon. Petitioner also reported that he'd had this pain since the 2012 accident. He agreed with Dr. deGrange that the records did not indicate neck pain, but that "there is nothing in there that accounts for the continued interscapular pain." While deGrange noted Petitioner had epidurals, Dr. Raskas noted he actually had a diagnostic nerve block with transient relief. The report stated: "I think at this point to state that the patient did not have any injury to his neck, ignores the fact that potentially this interscapular pain that he experiences is referred from the C5/6 level", and ignores the initial pain diagram and Petitioner's stated history. His 1/28/16 report, as well as his testimony, indicates that Dr. Raskas opined, after reviewing the second pain diagram from 1/29/14 from Midwest Occupational, that both accidents were contributing factors to the interscapular pain, but that the symptoms had been a temporary aggravation of the cervical condition. (Px6).

On cross examination, Dr. Raskas admitted that the initial Memorial Hospital records from 2/7/12 did not indicate complaints of interscapular pain. He also agreed that Dr. Wayne did not direct any treatment to the cervical spine, but noted that the thoracic area would be considered interscapular, and that Dr. Wayne's 3/13/14 report noted tenderness in the left lower medial scapular borders. He agreed that there were he found no objective abnormalities in his examinations of Petitioner. Dr. Raskas acknowledged that when Petitioner saw Dr. Wayne he was working his regular job and was found to be at MMI, and didn't return again until about 8

months later. He agreed there was no objective reason to restrict the Petitioner's activities, though he was not aware of Petitioner's specific job duties. He testified that Petitioner doing what he could tolerate and just deal with the pain wasn't going to "necessarily, absolutely change the situation anymore." He agreed his 1/28/16 report opined that the 1/28/14 incident was nothing more than a temporary aggravation. Dr. Raskas agreed that he did not have any independent knowledge or information regarding any of Petitioners' complaints or difficulties since he last saw him on 4/17/15, but that it was his understanding that no further treatment was being authorized following Dr. deGrange's report. He agreed that the symptoms coming from C5/6 could wax and wane. He also agreed that it did not appear that the disc was impacting the nerve root as Petitioner did not complain of radicular symptoms. (Px6).

On redirect examination, Dr. Raskas testified that the general pain distribution for a C5/6 disc protrusion would be pain down the arm into the thumb and index finger. However, if the protrusion is not compressing the nerve root, it can irritate the small fibers in the back wall of the disc and pain in the interscapular area is well recognized to be referred from C5/6 or C6/7. Dr. Raskas also testified that the Petitioner had relief with the injections performed, and had been willing to work through his pain. Dr. Raskas indicated, after reviewing his records, that he had continued Dr. Wayne's restriction of no use of vibratory tools. (Px6).

Respondent deposed board certified physiatrist Dr. Wayne on 10/25/16. He testified he had not discussed this case with Dr. Raskas. Dr. Wayne testified that he did not refer Petitioner to Dr. Raskas. On 2/20/14, Petitioner reported mid and low back pain after the second accident. He did not report neck pain, but in what appears to be a check box "review of systems", Petitioner checked off neck pain. Dr. Wayne testified that the interscapular area overlaps with the mid back. Petitioner indicated mid to lower thoracic symptoms, which is towards the bottom part of the scapula. Petitioner reported diffuse tenderness in the mid to lower thoracic spine, and pain with bending and range of motion in that area. Dr. Wayne did not examine the neck, indicating there was no clinical indication to do so. (Rx2).

Dr. Wayne agreed the 1/28/14 report from Midwest Occupational noted no cervical tenderness on exam. Dr. Wayne explained that he performed trigger point rather than epidural steroid injections because he believed that the symptoms were muscular in nature. He also never recommended an MRI of the spine, and released the Petitioner to full duty as of 3/29/14. (Rx2).

Dr. Wayne testified that Petitioner reported pain in the upper thoracic and scapular area on 4/9/14, and that this was an entirely different region of complaint from prior visits and the first time he indicated such complaints. He agreed that this area of symptoms could be consistent with a cervical spine injury, and most commonly from the C5/6 level. Petitioner did not relate what brought on the new symptoms in the right upper thoracic and scapular region. Dr. Wayne diagnosed mid-to-low thoracic and lumbar strains on 4/9/14, opined that Petitioner did not require any additional testing or treatment for the cervical spine, and Petitioner was released to return to full duty. (Rx2).

On 1/20/15, Petitioner reported worsening pain in the upper to mid thoracic region radiating to the base of the neck on the right side, as well as low back pain. Petitioner had indicated his job had changed to working on a grinder. Dr. Wayne thought there was some overlap of the 1/20/15 complaints with those from the April 2014 visit. Dr. Wayne understood from Petitioner that the symptoms had improved somewhat between those visits but had not resolved.

On 1/20/15, Dr. Wayne testified it still appeared to him that Petitioner was experiencing muscle-related pain. He thus prescribed a muscle relaxer, a pain patch, and the option of physical therapy, which Petitioner declined. Dr. Wayne opined, based upon his review of outside medical records, histories from Petitioner, and clinical exam,

that the 1/28/14 accident did not cause the Petitioner's cervical complaints. He did advise Petitioner to avoid vibratory tools if they caused him problems. (Rx2).

On cross examination, Dr. Wayne testified Petitioner was referred to him by the Respondent's insurer. He agreed that a portion of Petitioner's thoracic and lumbar symptoms were causally related to the 1/28/14 accident, and that a portion of them were related to the 2/7/12 accident. He also agreed Petitioner reported neck and right arm pain in an intake form on 2/20/14, but the cervical spine was not examined that day. Dr. Wayne testified that the trigger point injections performed in the lower thoracic region below T7 would not be expected to help complaints in the upper thoracic region. Dr. Wayne could not say why Petitioner's treatment was transferred to Dr. Raskas. (Rx2).

Respondent's Section 12 examiner, board certified orthopedic surgeon, Dr. DeGrange, testified via deposition on 9/27/16. (Rx1). He performed examinations of Petitioner at Respondent's request on 6/16/15 and 9/6/16, and he prepared an addendum report between these exams on 12/8/15. At the 6/16/15 exam, Petitioner indicated a large piece of metal fell across his left shoulder and back, and that he reported pain in the left leg, top of the left shoulder and the left flank. He didn't report whether he had neck pain. Dr. deGrange reviewed the 2/7/12 emergency room records, noting no documented neck pain or diagnostic cervical testing. He would have expected these things had the Petitioner reported a significant neck injury. Dr. deGrange reviewed the Midwest Occupational records as well, and noted he found no mention of neck pain. (Rx1).

Dr. deGrange testified that Petitioner sought next sought treatment for the spine on 1/29/14 with Midwest Occupational, and he noted no report of neck pain. Dr. deGrange was not aware of any medical treatment between 2/20/12 and 1/29/14. He testified the records from Dr. Wayne through April 2014 noted complaints of right thoracic and lumbar pain. Dr. deGrange's 6/16/15 exam noted diffuse tenderness without spasm from the base of the skull through the interscapular area and along the medial borders and spines of both shoulder blades. There was reduced range of motion. Neurological exam was within normal limits. There was positive Tinel's at the wrists bilaterally which could represent carpal tunnel syndrome. (Rx1).

Dr. deGrange reviewed the 2/28/15 cervical MRI films and indicated that, while the radiologist noted bilateral stenosis at C5/6, he did not find this to be clinically significant because there was not sufficient compression to result in symptoms, and Petitioners' complaints and physical exam findings were not consistent with radicular compression. (Rx1). As to the right shoulder MRI, Dr. deGrange indicated that there was some pathology there, but that Dr. Solman did not find it to be clinically significant. (Rx1).

Dr. deGrange's diagnosis was cervical spine disc degeneration, and he opined that there was no medical causal relationship between the disc degeneration and the 2/7/12 work accident. He further opined that Petitioner was not a candidate for cervical spine surgery. (Rx1). Dr. deGrange's 12/8/15 addendum report indicated that Dr. Raskas' 8/11/15 report did not impact his own opinion that Petitioner's cervical condition was not causally related to the 2/7/12 accident. (Rx1).

At Dr. deGrange's 9/6/16 examination of Petitioner, he reported ongoing problems with his neck. Petitioner's cervical examination was essentially unchanged versus the 6/16/15 exam relevant to this case. Dr. deGrange also had reviewed Dr. Raskas' deposition transcript, as well as the 4/27/15 and 5/4/15 videos depicting the screening job. He did not observe Petitioner having any obvious distress or limitations involving the cervical spine while he was working. (Rx1).

After reviewing Petitioner's medical records to date, Dr. deGrange again opined that, based upon all the information available to him, Petitioner's neck complaints were not causally connected to the 2/7/12. He did

opine that surgery would not be unreasonable based upon the ongoing and persistent symptoms. He testified that medial scapular pain is a common symptom of C5/6 disc pathology, and stated: There was some degree of degenerative spurring, and owing to the passage of time and some medications and the persistence of symptoms, its not unreasonable four years down the road to recommend surgery for some ongoing and persistent symptoms." He opined that Petitioner did not have nerve root impingement, but had some sort of irritation of the nerve that was more of a radiculitis, with no neurological deficits but a chronic nagging pain. From an objective standpoint, he believed the Petitioner could return to work full duty. (Rx1).

On cross examination, Dr. deGrange agreed that he had not previously opined as to whether Petitioner's cervical condition or need for surgery is related to the 1/28/14 accident. As to his review of the videos, he had no knowledge of whether the Petitioner had used pain medications before the filming began. He denied telling the Petitioner in September 2016 that Petitioner's complaints were consistent with an injury and that he would make sure his surgery was taken care of. He reiterated that he agreed with the proposed surgery of Dr. Raskas. (Rx1).

On redirect examination, Dr. deGrange noted that Petitioner did not complain of neck pain to Midwest Occupation or Dr. Wayne in from 1/29/14 to 3/13/14. On recross, Dr. deGrange agreed that his 9/6/16 report stated that Petitioner first complained of symptoms referable to the cervical spine at Midwest Occupational on 1/29/14. He also agreed that Petitioner indicated neck pain as well as mid and low back pain in the review of systems with Dr. Wayne on 2/20/14, but that it would be a "leap" to equate that to having knowledge of symptoms referable to a cervical pathology. Again questioned by Respondent's counsel, he testified that while the 1/29/14 report of Midwest Occupational noted interscapular pain, that this in itself is non-specific, and that based on his experience and expertise his causation opinion remained unchanged. He did agree that the interscapular complaints appeared to continue from 1/29/14 to present. As there was no compelling evidence on MRI or examination that Petitioner's symptoms were due to nerve root compression, it was "hopeful" that the recommended surgery would improve Petitioner's condition. As to the 1/28/14 accident, Dr. deGrange opined that the mechanism of injury was not consistent with causing interscapular pain. (Rx1).

On the final redirect exam, Dr. deGrange explained that Dr. Wayne is a conscientious physician that treats spine conditions and was knowledgeable about anatomy, and if there was evidence of a cervical spine injury he would have at a minimum ordered cervical imaging. (Rx1).

The Arbitrator reviewed several videos submitted by the Respondent of the Petitioner's work activities. On 4/27/15, a different Respondent employee is depicted striking rail cars with a small sledgehammer using both hands to knock off bolts for approximately an hour. This included doing so at times while bending and reaching. On 5/4/15, the Petitioner himself is shown using an extended blow torch to break the brackets that hold screened metal panels onto the train cars. This includes overhead reaching and pulling of a hose. Once a portion was completed, he would then lift and move the screened panels from the cars and pile them on the ground, as well as maneuver the piles on the ground both by bending and lifting them into place or using his feet to move them. The first video was a little over an hour long, and the second 5/4/15 video was approximately the same length. This video showed the Petitioner removing other smaller pieces of panels, brackets and rails, which also involved significant bending, carrying and throwing the pieces, along with walking along the rail cars and raking. (Rx6).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the 2/7/12 accident. The causal connection finding applies to the condition diagnosed by Dr. Raskas at C5/6. The Arbitrator finds that any lumbar condition is not causally related to the 2/7/12 accident.

Dr. Raskas, following a review of Petitioner's prior medical records, on 3/6/15 opined: "(Petitioner) does describe pain in the thoracic spine and pain around his shoulder blades as stemming back after the 2012 work injury. (Petitioner) was involved in a fairly severe accident. I believe initially his flank pain and lumbar pain may have been more prominent. As those resolved the mid-back pain, which I believe may be coming from the cervical spine, became more prevalent. His current symptoms are directly attributable to the 2012 work injury." On 8/11/15, Dr. Raskas drafted a letter in which he opined the 2/7/12, work accident caused the C5/6 injury and need for surgery. On 1/28/16, Dr. Raskas prepared a report indicating his opinion that the 1/28/14 accident was more likely than not a temporary aggravation of the cervical condition that was causing referred pain to the interscapular area. His testimony indicated that both accidents were contributing factors to the interscapular pain, but that the symptoms following the second accident were a temporary aggravation of the cervical condition.

Significantly, in the Arbitrator's view, Dr. Raskas noted an undated pain diagram in the Midwest Occupational records that appeared to have been from the Petitioner's initial 2012 visit. The diagram clearly shows that Petitioner indicated sharp pain between the shoulder blades, despite this complaint not being mentioned by PA Colon in the report of 10/27/14. While the fact it is undated leads to a lack of clarity as to when it was from, there is a separate dated pain diagram from Petitioner's initial visit after the 1/28/14 incident. It stands to reason that the undated form would thus be from his initial visit in 2012. Thus, it appears to the Arbitrator that the Petitioner has had pain in the area between his shoulder blades since the 2012 accident.

Dr. Raskas credibly testified that interscapular area pain can be referred from C5/6 or C6/7. Dr. Raskas also testified that the Petitioner had relief with the injections performed, and had been willing to work through his pain. Dr. Raskas indicated, after reviewing his records, that he had continued Dr. Wayne's restriction of no use of vibratory tools. He noted that the thoracic area would be considered interscapular, and that Dr. Wayne's 3/13/14 report noted tenderness in the left lower medial scapular borders.

While Dr. Raskas agreed on cross exam that there were no objective abnormalities in his examinations of Petitioner, he testified that the disc was not impacting a nerve root. He also testified that the symptoms from C5/6 could wax and wane. Petitioner had a significant gap in treatment of 8 months with full duty work after being released by Dr. Wayne, but Dr. Raskas testified that he believed Petitioner was doing what he could tolerate and dealing with the pain. While he agreed he hadn't seen Petitioner since 4/17/15, but that it was his understanding that no further treatment was being authorized by Respondent based on the opinions of Dr. deGrange.

The Arbitrator would also note that the evidence indicates the Petitioner does not appear to have sought treatment with any doctor of his own choosing in this case, but rather went for initial visits to new providers based on scheduling by the Respondent.

While on 6/16/15, Section 12 examiner Dr. deGrange opined that there was no cervical injury as a result of the 2/7/12 work accident, on 9/6/16 he did not dispute the surgery recommended by Dr. Raskas based on Petitioner's persistent complaints at that time. Petitioner reported at that time that his symptoms worsened with work activities, particularly with prolonged or repetitive overhead work and use of vibratory tools, and that he had not been performing much railcar screening work at that time because such work hadn't been available.

While Dr. deGrange noted Petitioner had epidurals, Dr. Raskas testified the injections were actually diagnostic nerve blocks, and that Dr. deGrange's reliance on a lack of a "neck" injury in his opinions ignored the fact that Petitioner's interscapular complaints were referred from the C5/6 level, with such complaints being supported by the initial pain diagram and Petitioner's stated history.

Dr. deGrange testified that medial scapular pain is a common symptom of C5/6 disc pathology, and stated: "There was some degree of degenerative spurring, and owing to the passage of time and some medications and the persistence of symptoms, its not unreasonable four years down the road to recommend surgery for some ongoing and persistent symptoms." He opined that Petitioner did not have nerve root impingement, but rather had a chronic, nagging pain. In testimony, he did agree that the interscapular complaints appeared to continue from 1/29/14 to present.

Dr. Wayne testified that Petitioner reported pain in the upper thoracic and scapular area on 4/9/14, and that this was an entirely different region of complaint from prior visits and the first time he indicated such complaints. He agreed that this area of symptoms could be consistent with a cervical spine injury, and most commonly from the C5/6 level. However, this opinion does not appear to take into account the initial pain diagram from Midwest Occupational. The Arbitrator believes this is an important point. A part of the Respondent's defense in this case has been a lack of neck complaints. However, the Petitioner has credibly testified that he never really had a "neck" problem, but rather had pain from between the shoulder blades to the base of the neck.

On cross examination, Dr. Wayne appeared to agree that a portion of Petitioner's thoracic and lumbar symptoms were causally related to the 1/28/14 accident, and that a portion of them were related to the 2/7/12 accident. He also agreed Petitioner reported neck and right arm pain in an intake form on 2/20/14, but that the cervical spine was not examined that day.

As to the note of Dr. Wayne indicating inconsistency in Petitioner saying his mid back pain had returned to baseline while low back pain remained worse, and then "altered" his story to indicate that his thoracic pain was actually currently more severe than his lumbar pain, the Arbitrator does not see this as inconsistent. The Petitioner has clearly indicated that the pain between his shoulder blades has been a chronic problem for him and thus not as "severe" as the increased low back pain at that particular time.

The gaps in treatment while the Petitioner performed what was obviously heavy duty work has been fairly questioned by Respondent as supporting the opinion that the current cervical condition is not causally related to either the 2/7/12 or 1/28/14 accidents. In most cases, the Arbitrator would consider such gaps to support the argument that an initial condition's causal relationship to an accident may have ended. In this particular case, the Arbitrator believes the Petitioner testified credibly with regard to the reasons for these gaps, significantly with regard to the gap following the initial 2/7/12 injury as being at least in part due to working with the Respondent's request to try to avoid a lost time accident. Even during times where Petitioner's duties were being restricted close in time to the accident dates, he testified that he was continuing to perform his regular work duties, and it seems clear to the Arbitrator is that the inference is that the Respondent was a willing partner in allowing him to do so. That is particularly the case when the Petitioner was treating with the company clinic, Midwest Occupational, and given the Petitioner's testimony that a nurse case manager was involved in scheduling him and attending at least some visits. The Petitioner is obviously not an invalid in that he has continued to perform heavy duty work. However, he also has continued to do so without incurring temporary total disability. The Arbitrator believes the evidence supports the fact that the Petitioner is a hard worker, has toughed it out despite what appears to be nagging but non-disabling pain, and has been able to function in part because his actual work performed in de-screening rail cars allowed him to only perform heavy physical work for 3 or 4 hours per day. This testimony was unrebutted. It appears to the Arbitrator that it was only when the

Petitioner was placed into lighter duty positions, with a grinder and picking up garbage, which involved longer physical work hours that he began to have difficulty continuing to work.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner is entitled to the medical expenses contained in Petitioner's Exhibit 7 related to treatment of the Petitioner's cervical and thoracic spines, as well as the right shoulder. No physician has credibly opined that the treatment received by Petitioner to date has been unreasonable or unnecessary.

The award of the noted medical expenses in this case for the cervical and thoracic treatment includes the treatment incurred subsequent to 1/28/14. However, with regard to any lumbar treatment, the only such treatment that is related to the case at bar, and which is thus awarded by the Arbitrator, would be the lumbar treatment incurred prior to 1/28/14.

The Arbitrator notes that the parties have stipulated that any awarded medical expenses may be paid by the Respondent pursuant to the fee schedule and directly to the providers. The Respondent is entitled to credit for any of the awarded bills that were paid prior to hearing.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the surgery recommended by Dr. Raskas, namely a C5/6 fusion, is reasonable and necessary. The Arbitrator, above, has determined that the C5/6 condition is causally related to the 2/7/12 accident. As such, the Respondent shall authorize the C5/6 fusion surgery, pursuant to Sections 8(a) and 8.2 of the Act.

Dr. Solman opined Petitioner did not have a surgical problem in the right shoulder, diagnosing cervical pathology and mild right shoulder biceps tendonitis. Once this was ruled out, Dr. Raskas opined that this would support C5/6 as the source of Petitioner's complaints. Additionally, while he disputed a causal relationship of the surgery to the Petitioner's employment, Dr. deGrange testified that he did not dispute that the planned surgery would be reasonable. The preponderance of the evidence supports the C5/6 surgery recommended by Dr. Raskas is reasonable and necessary treatment pursuant to Section 8(a).

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

Jeffrey Stover,

Petitioner,

vs.

NO: 17 WC 11599

18IWCC0447

State of Illinois - Centralia Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 9, 2018, 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: JUL 19 2018
TJT:yl
o 7/10/18
51

David L. Gore

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STOVER, JEFFREY
Employee/Petitioner

Case# **17WC011599**

SOI/CENTRALIA CORECTIONAL CENTER
Employer/Respondent

18IWCC0447

On 1/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
SHANNON D RIECKENBERG
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

JAN 9 - 2018

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

18IWCC0447

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

JEFFREY STOVER
Employee/Petitioner

v.

STATE OF ILLINOIS / CENTRALIA CORRECTIONAL CENTER
Employer/Respondent

Case # 17 WC 11599

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 8, 2017**. By stipulation, the parties agree:

On the date of accident, **February 13, 2017**, 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 **$64,291.00**, and the average weekly wage was **$1,236.37**.

At the time of injury, Petitioner was **29** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$1,059.79** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,059.79**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$741.82 per week** for **35.475 weeks**, because the injuries sustained caused the loss of use of **16.5% of the right leg**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **July 12, 2017** through **November 8, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

January 3, 2018
Date

JAN 9 - 2018

STATEMENT OF FACTS and CONCLUSIONS OF LAW

Petitioner was a 17 year Correctional Officer (CO) at Respondent's Centralia Correctional Center Facility when he sustained accidental injuries on 2/13/17. While responding to a fight in the south yard, he was running and jumped over a mud hole at the edge of the basketball court, landing with his right leg. He testified that he felt immediate pain in his right kneecap and swelling. He denied any prior right leg injuries or surgeries.

The Respondent submitted a 1/13/17 report from the Urgent Care Triage at the Marion VA Medical Center with complaints of a history of left elbow pain, as well as right knee pain at the lateral front and back of the knee after running the night before. Petitioner indicated he had not fallen or twisted his knee. Right knee x-rays reflected I findings included significant progression in anterior compartment osteoarthritis with increasing joint space narrowing, development of chondrocalcinosis, and development of prominent joint effusion with no acute pathology. Petitioner was diagnosed with right knee degenerative joint disease and advised to increase his use of Diclofenac and to avoid running until the pain resolved. (Rx5).

Following the accident date, the Petitioner presented to Urgent Care Triage at the Marion VA Medical Center on 2/15/17. He reported initially being seen at the health care clinic at the Centralia facility. He reported developing

right knee pain running at work two days prior. Per the triage note: "Two days ago was running at work (work related) and when he came down on right leg, felt pain in right knee. He has had pain and swelling around the patella and posterior knee since then." There is a separate note of Dr. Chowdhury which stated that he injured his right knee while had a misstep while trying to go down the stairs two days prior, and he denied swelling. He rated his right knee pain at 4/10 with activity and 1/10 with rest. Petitioner was given a Toradol injection and was advised to rest and take pain medications. X-rays and an orthopedic consult were also ordered. (Px3).

Petitioner followed up at the VA with orthopedics' Dr. Begley on 3/1/17. Petitioner indicated he had sustained a twisting injury to the right knee while running and jumping over a puddle at work to address a fight, landing hard. He noted immediate sharp, stabbing pain and swelling and difficulty with weight bearing, but was able to continue working. Following exam, Dr. Begley diagnosed a grade I right knee acute lateral collateral ligament tear with possible internal derangement and pre-existing low-grade osteoarthritis. Petitioner was advised to modify his activities, including light duty, to continue his prescribed pain medications (Tramadol and Diclofenac), and to use a hinged brace. A 3/8/17 right knee MRI was scheduled. (Px3).

On 3/8/17, Petitioner sought treatment with orthopedic surgeon Dr. Mall, testifying he went there for a second opinion. He reported a consistent history of right knee pain following a 2/13/17 injury at work where he jumped over a puddle to respond to a fight in the yard, landing awkwardly. Dr. Mall's report also states: "He had seen the orthopedic doctor at this facility in the past for his opposite knee and therefore felt comfortable with him for evaluation and management of his right knee condition." Dr. Mall diagnosed a right knee strain, possible meniscus tear, and possible patellar tendon injury. Dr. Mall indicated the mechanism of injury could have caused a meniscal tear. Petitioner was placed on light duty and physical therapy was prescribed pending MRI. (Px4).

On 3/16/17, Petitioner underwent an initial therapy evaluation at Hamilton Memorial, and continued to attend therapy through 4/14/17. (Px6).

A 3/31/17 right knee MRI reflected: 1) Subtle linear tear posterior horn medical meniscus, probably a full thickness tear which at least represents grade II signal abnormality; 2) an 8x15 mm area of severe cartilaginous thinning and defect in the mid to posterior weight bearing aspect of the medical femoral condyle without loose body or subchondral change; and, 3) joint effusion. (Px5).

While there was no progress note, a work note of Dr. Mall from 3/31/17 continues light duty while partial meniscectomy surgery was pending. (Px4). On 6/1/17, Petitioner underwent a partial medial meniscectomy and chondroplasty of the medial femoral condyle, patella and trochlea, as well as a two-compartment synovectomy of the medial and patellofemoral aspects of the synovial plica. (Px7).

Petitioner followed up with Dr. Mall on 6/14/17, indicating he was doing well and had minimal complaints. Post-surgical therapy for strength and range of motion was recommended, and Petitioner was allowed to return to work light duty and to return to full duty work as of 6/28/17. Petitioner last saw Dr. Mall on 7/12/17. He was noted to be doing quite well, noting he was back to biking nine miles a day but had yet to do any jogging. Petitioner continued to work full duty without restrictions and was placed at maximum medical improvement. (Px4).

At hearing, the Petitioner testified that he was a very active triathlete, and that he biked or ran on a daily basis. He testified he can no longer participate in races since the accident because he can no longer run the necessary distances. He can run maybe a half mile, maybe more on a good day. After running, his knee will swell and be sore for several days, and he is required to use ice. He has attempted to run many times, but has not seen much

improvement in his ability to do so. He can bike without significant problems, and has no issues with swimming. He no longer uses a knee brace, but testified he takes Diclofenac (NSAID) from the VA, as well as over the counter chondroitin and glucosamine.

On cross examination, Petitioner testified he currently works for the Respondent as a chapel officer for half the day, and a tower officer the rest of the day. He reported having pain while climbing the tower stairs at work. He agreed he is not under any work restrictions, and has been able to perform his job. He can run at work if needed, but he tries not to. He testified he had been taking Diclofenac since leaving the military because he was having joint problems with arthritis.

The Petitioner testified he had absolutely no prior right knee problems and had sought no prior right knee treatment. He was shown the 1/13/17 report from the VA (Rx5), and testified that the report was mistaken about his problem being the right knee at that time. He agreed that he generally has treated at the VA for everything since leaving the military. Respondent's counsel then asked the Petitioner to review the report in light of comments from his attorney that the report indicated the wrong knee, and the Petitioner agreed the report pertained to him, indicating he ran a lot and had injuries at time, and that he did not dispute the report's indication that he complained of his right knee at that time. Asked to clarify his testimony on redirect, the Petitioner agreed that he had prior left knee treatment, and that the report may have mistakenly indicated his right knee.

Major Theodore McAbee testified on behalf of Respondent. A shift supervisor, he testified he has known the Petitioner since he started with the Respondent, and that he is a good employee with no issues. He verified Petitioner's current duties as a chapel officer and a tower officer, which includes climbing three flights of stairs as tower officer, acknowledging that Petitioner came to him and requested these positions because he needed a break from his regular CO job. Major McAbee agreed that given Petitioner has no restrictions, he would have no problem putting him back to work as a CO if needed.

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors

used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial AMA impairment report or rating was submitted into evidence by either party. Therefore, this factor has no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a correctional officer at the time of the accident and that he was able to return to work in his prior capacity as a result of said injury. He testified that he requested a move to a position where he splits time as a chapel officer and tower officer to assist with his knee condition. However, he has no medical work restrictions per his surgeon, Dr. Mall. The Arbitrator notes that there does appear to be situations as a CO where the Petitioner would have to run to deal with an inmate situation, as occurred on the date of accident, and as such his leg and knee are involved with his regular job more than someone, for example, working a desk job. The Arbitrator gives this factor some weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident. Neither party has submitted evidence into the record which supports the impact of Petitioner's age on his permanent condition. As such, the Arbitrator gives this factor no significant weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner was able to return to his regular job as a CO before transferring into a more specified CO job involving the chapel and a tower. No evidence was received by the Arbitrator which would indicate the Petitioner has suffered a loss of future earning capacity, particularly given he currently is under no work restrictions as a result of his injury. This factor is given some weight, and tends to show a lesser level of permanency on average.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the last report of Dr. Mall indicates the Petitioner had resumed biking 9 miles per day, but was still not running. The Petitioner testified that he has ongoing problems with any prolonged running, as well as stairs, and that this has impacted his prior lifestyle as a triathlete. The medical records in evidence indicate that the Petitioner sustained a partial meniscal tear as a result of the accident, but also that he had a preexisting level of degeneration at the medial femoral condyle, both of which were addressed to some level with the 6/1/17 surgery. While the Petitioner attempted to testify that he had no prior right knee problems, the records of the VA are clear that he had right knee complaints and a right knee x-ray taken just a month prior to the accident in this case.

Based on the above factors, the record taken as a whole and a review of prior awards of the Commission with similar injuries and outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 16.5% loss of use of the right leg pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kim Siriann,

Petitioner,

vs.

NO: 12 WC 27818

18IWCC0448

Flagg Creek Water Reclamation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, permanent partial 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 31, 2016, is hereby affirmed and adopted.

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

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

18IWCC0448

The party commencing 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: JUL 19 2018
TJT:yl
o 7/10/18
51

David L. Gore

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIRIANN, KIM
Employee/Petitioner

Case# **12WC027818**

FLAGG CREEK WATER RECLAMATION
Employer/Respondent

18IWCC0448

On 3/31/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

0059 BAUM RUFFOLO & MARZAL LTD
JOEL HERRERA
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
JEFF RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

18IWCC0448

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kim Siriann
Employee/Petitioner

v.

Flagg Creek Water Reclamation
Employer/Respondent

Case # **12** WC **27818**

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 **Wheaton**, on **February 26, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 10, 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 *as explained infra.*

In the year preceding the injury, Petitioner earned **$48,139.52**; the average weekly wage was **$925.76**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of **$16,344.88** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$16,344.88**.

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

ORDER

Temporary Total Disability Benefits

Respondent shall pay Petitioner temporary total disability benefits of $617.17/week for 123 & 1/7th weeks, commencing November 11, 2011 through November 20, 2011 and November 29, 2012 through March 30, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from November 11, 2011 through February 26, 2016, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be entitled to a credit of Petitioner's $16,344.88 for temporary total disability benefits paid.

Maintenance Benefits

As explained in the Arbitration Decision Addendum, Petitioner's claim for maintenance benefits from April 1, 2015 through February 26, 2016 is denied.

Permanent Partial Disability Benefits

As explained in the Arbitration Decision Addendum, Respondent shall pay Petitioner permanent partial disability benefits of $555.46/week for 64.5 weeks, because the injuries sustained caused the 30% loss of the left leg (knee), as provided in Section 8(e) of the Act.

Penalties

As explained in the Arbitration Decision Addendum, Petitioner's claim for penalties pursuant to Sections 16, 19(k) and 19(l) of the Act is denied.

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

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

Signature of Arbitrator

March 29, 2016
Date

ICArbDec p. 3

MAR 31 2016

18IWCC0448

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Kim Siriann
Employee/Petitioner

v.

Flagg Creek Water Reclamation
Employer/Respondent

Case # **12** WC **27818**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include causal connection, Petitioner's entitlement to temporary total disability commencing on November 11, 2011 through November 20, 2011 and from November 29, 2012 through March 30, 3015, Petitioner's entitlement to maintenance benefits from April 1, 2015 through February 26, 2016, the nature and extent of Petitioner's injury as well as whether penalties should be imposed on Respondent pursuant to Sections 16, 19(k) and 19(l). Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Kim Siriann (Petitioner) testified that she was employed by Flagg Creek Water Reclamation District (Respondent) beginning on November 2, 2002 as the Administrative Payroll/Billing Coordinator. Tr. at 26-27. Beginning in July of 2011, Petitioner testified that she no longer did payroll. but she still did the billing and administrative tasks around the office. Tr. at 27.

Petitioner described her job duties to include entering meter readings from all of the surrounding villages into a computer and produce 5,000-8,000 customer bills at the end of each month. Tr. at 27-28. Petitioner also maintained the office supplies. Id. During the billing period, Petitioner testified that she would help stack 8,000 bills in a USPS box and haul them off to a truck, and then someone from the plant would take it to the post office. Tr. at 28.

Petitioner also explained that as a billing coordinator she was sitting down approximately 70% of the time with the remaining 30% of her time spent running around getting meter readings and performing tasks such as billing, filing, pulling permits, covering for other employees at lunch, etc. Tr. at 29. Petitioner also testified that she and a co-worker would stack bills maybe four boxes high on a dolly and bring them into the billing room each billing cycle. Tr. at 29. Also, two to four times per year she would mark and pack meter readings into boxes and take those upstairs to the attic for the seven year retention period. Tr. at 29-30.

Petitioner estimated that she carried billing boxes weighing about 30 pounds when performing billing functions. Tr. at 30. She also testified that she did some, but not much, squatting and kneeling to get into the lower drawers of filing cabinets. Id. Petitioner also explained that, while every day was different, during the billing cycle she was on her feet all day and was constantly moving around. Tr. at 31.

On cross examination, Petitioner testified that the majority of her job for Respondent required her to be at a

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. The Arbitration Hearing Transcript is denominated as "Tr." with corresponding page numbers.

desk, but she would squat or kneel on a daily basis to get in and out of cabinets. Tr. at 66-69. She testified that on a regular basis she would have to lift 30-40 lbs. when she was carrying meter readings to place them into drawers, boxes of bills, or cases of water as needed. Tr. at 70-71. Petitioner acknowledged that she was able to get up and move around as needed. Id.

November 10, 2011

On November 10, 2011, Petitioner sustained an injury to her left knee at work. Tr. at 33. She testified that she was sitting in her chair in a small cubical facing forward with a wide, but low 18-inch filing cabinet located behind her. Id. Petitioner testified that she stood up from her chair and turned to the left when her foot got caught underneath an open drawer causing her to lose her balance and fall to the left. Tr. at 33-34. She injured her left knee and a lot of people came running to help her. Tr. at 34. Petitioner explained that her left knee swelled immediately and it was not easy to walk. Tr. at 34-35. She sat there and ate lunch, but her pain persisted so she asked her supervisor, Michael Lynch (Mr. Lynch), if she may be excused to follow up at the Immediate Care Center of Palos Community Hospital. Tr. at 35.

Many years earlier, Petitioner had a prior left knee injury when she was in high school in 1977. Tr. at 56-57. Petitioner testified that she was playing baseball and slid into second base causing her to jam her knee. Id. Her knee swelled and she sought treatment with Dr. Regan who removed fluid from underneath the kneecap. Id. Since that time, Petitioner has not required any other treatment to her left knee or had any knee pain aside from the work injury. Tr. at 57.

Medical Treatment

Petitioner went to Palos Community Hospital on November 10, 2011 where she provided a consistent mechanism of injury and did not return to work the following day. PX1 at 57-61; Tr. at 46. She was released with instructions to follow up with her primary care physician, Dr. John Panozzo. Id. On November 14, 2011, Petitioner went to Work Right Occupational Health as referred by Respondent. PX2 at 2-6. She was diagnosed with a left knee strain and placed off work until November 21, 2011. Id.

Petitioner then commenced treatment with Dr. Thomas Regan at Southside Orthopedics in mid-December 2011. PX3 at 10. She reported left knee pain and difficulty using stairs. Id. On examination, Dr. Regan noticed swelling, decreased quad tone and tenderness posterolaterally and posteromedially. Id. He ordered an MRI of the left knee, which Petitioner later underwent at Open Advanced MRI. Id.; PX3 at 14; PX4. The interpreting radiologist noted a possible intrasubstance injury to the PCL without complete disruption and chronic pain of the medial collateral ligament. PX3 at 14. Following the MRI in December, Dr. Regan recommended that Petitioner use crutches and he ordered physical therapy on January 5, 2012. PX3 at 9.

Petitioner underwent physical therapy at Heights Physical Therapy and Sports Institute beginning in January or 2012. PX5. After further examination, Dr. Regan ordered a second MRI which Petitioner underwent in March 2, 2012. PX3 at 8, 15. The MRI revealed a posterior medial meniscocapsular sprain with adjacent small delicate intrameniscal tear. Id. On April 5, 2012, Dr. Regan ordered and administered a cortisone injection, but Petitioner reported that the injection only provided minimal and temporary relief as of June 7, 2012. PX3 at 7-8.

First Section 12 Examination – Dr. Cole

On May 3, 2012, Petitioner was examined by Dr. Brian Cole at Respondent's request. RX3. Dr. Cole took a

history from Petitioner, reviewed various treating medical records and rendered opinions regarding Petitioner's left knee condition and its relatedness, if any, to her accident at work. Id. He diagnosed Petitioner with early chondrosis of the left knee consistent with early osteoarthritis and a posterior horn medial meniscal tear. Id. Dr. Cole recommended a series of viscosupplementation injections which, if unsuccessful, would be followed by surgery. Id. He indicated that Petitioner could work as a billing coordinator without restrictions. Id.

Work Status and Continued Medical Treatment

During the period of November 21, 2011 through July 2, 2012, Petitioner testified that she worked regular duty. Tr. at 48. Following her accident she explained that she was off work from November 11, 2011 through November 20, 2011. Tr. at 46-47. Petitioner testified that she did not know how workers' compensation worked so she used her sick or vacation time. Id. She then returned to work through July 6, 2012. Tr. at 47.

Petitioner explained that during this period of time she was performing most of the same work duties. Tr. at 48. However, she brought a pillow and put it on top of her computer tower to keep her knee elevated. Tr. at 48-49. Petitioner explained that her leg could only stay in a position for so long and then she would have to bend it, put it back down and stand up and walk which she was doing throughout the day. Id.

Petitioner's last day of work was July 2, 2012 and on July 6, 2012 she received a letter in the mail terminating her employment for insubordination. Tr. at 47. Petitioner understood that the insubordination was because she refused to sign a HIPAA form relating to her family's history. Id.

The medical records reflect that Petitioner continued to follow up with Dr. Regan through November 29, 2012. PX3 at 7. After months of failed conservative treatment, she elected to proceed with a recommended arthroscopic examination of the left knee. Id.

Second Section 12 Examination – Dr. Cole

On October 15, 2012, Dr. Cole re-examined Petitioner. RX3. He diagnosed Petitioner with patellofemoral pain in the left knee with an incidental medial meniscal tear. Id. He opined that surgery was appropriate, but Petitioner's prognosis was guarded. Id.

Continued Medical Treatment

On November 30, 2012, Petitioner underwent an arthroscopic debridement of the patella and medial femoral condyle with Dr. Regan. PX1 at 45-46; PX3 at 12-13. Petitioner testified that she was kept off work by her doctor from November 30, 2012 forward. Tr. at 50. She explained that neither Dr. Regan nor Dr. Tonino advised her that she could return to work without restrictions after her first surgery. Tr. at 52.

Dr. Regan released Petitioner to return to desk duty commencing on January 17, 2013. PX3 at 6, 19. However, during the visit on February 14, 2013, Dr. Regan continued Petitioner's physical therapy as she was not improving and placed her off work. PX3 at 6, 21.

Third Section 12 Examination – Dr. Cole

Petitioner submitted to a third evaluation with Dr. Cole at Respondent's request on February 7, 2013. RX3. Petitioner reported that she felt close to being able to return to full duty work, but she would have difficulty with squatting, kneeling, climbing or with any significant lifting. Id. Dr. Cole diagnosed Petitioner with anterior left

knee pain still recalcitrant to conservative management. Id. He noted that only mild chondrosis was found intraoperatively three months earlier. Id.

Dr. Cole indicated that Petitioner's level of impairment at that time was mild and that her job description was such that her job was not a heavy one and it was orthopedically safe and reasonable for her to return to work full duty. Id. He noted that, "[t]his is not to suggest that she would not have subjective discomfort in working this full-duty job; however, I am stating that she is orthopaedically safe to do so, and she would not endanger, worsen, or progress the condition of her left knee if she were to work on the knee and use it full duty, with no restrictions." Id. Dr. Cole indicated that Petitioner should continue with physical therapy three times per week for eight weeks and that she would be at maximum medical improvement thereafter. Id.

Continued Medical Treatment

Petitioner returned to Dr. Regan in March and May of 2013 with persistent symptoms. PX3 at 5. Dr. Regan recommended a repeat MRI and a second opinion with Dr. Pietro Tonino. Id.; PX6 at 16-21. He also kept Petitioner off work until further notice and reiterated that she should follow up with Dr. Tonino on November 7, 2013. PX3 at 5, 21-24; PX6 at 16-21.

Fourth Section 12 Examination – Dr. Cole

On July 15, 2013, Petitioner returned to Dr. Cole for a fourth examination at Respondent's request. RX3. Dr. Cole agreed that a repeat MRI would be reasonable as would be a cortisone injection. Id. He opined that Petitioner was not yet at maximum medical improvement and that her condition continued to be related to the work injury. Id. However, Dr. Cole also indicated that Petitioner could continue to work without restrictions. Id.

Continued Medical Treatment

On August 22, 2013, Petitioner saw Dr. Tonino for initial consultation. PX6 at 16-21. Petitioner reported a consistent history of the work accident and subsequent medical treatment. Id. Dr. Tonino diagnosed Petitioner with chondromalacia and ordered a left knee MRI to determine if Petitioner had any other significant internal derangement that could be causing her symptoms. Id. Petitioner underwent the recommended MRI on November 1, 2013 and revealed a sprain or partial tear of the posterior cruciate ligament and mild chondromalacia in the lateral facet of the patella. PX3 at 16-17.

Addendum Report – Dr. Cole

Dr. Cole authored an addendum report dated December 29, 2013. RX3. He reviewed Petitioner's recent MRI and found that chondrosis of the lateral patellar facet, with no subchondral bone marrow edema. Id. He also noted subtle changes in the posterior horn of the medial meniscus which were not clinically relevant because Petitioner had not reported medial pain as of his last physical examination. Id. Dr. Cole opined that Petitioner was at maximum medical improvement with no need for further medical care. Id.

Continued Medical Treatment

On January 9, 2014, Dr. Tonino reviewed Petitioner's recent MRI and ordered an arthroscopic surgery with probably chondroplasty. PX6 at 22-28. He noted that Petitioner may have some arthrofibrosis. Id.

On April 16, 2014, Petitioner underwent a partial synovectomy and chondroplasty with Dr. Tonino. PX6 at 41-42. Intraoperatively, Dr. Tonino found extensive patellofemoral synovitis which was debrided arthroscopically. Id. He also debrided the medial femoral condyle which showed a small area of Grade 3 chondromalacia near the intercondylar notch. Id.

Petitioner returned to Dr. Tonino post-operatively and he ordered physical therapy, which Petitioner underwent at ATI from April 2014 through June 2014. PX6 at 89-92; PX7.

Fifth Section 12 Examination – Dr. Cole

On June 9, 2014, Dr. Cole examined Petitioner for a fifth time. RX3. He noted that Petitioner was eight weeks post-operative from her second left knee surgery and that she continued to complain of anterior and posterior knee pain. Id. Dr. Cole recommended that Petitioner continue using non-steroidal anti-inflammatory medications, finish her course of post-operative physical therapy over the next four weeks and he reiterated that she could safely work full duty. Id. Dr. Cole estimated that Petitioner would reach maximum medical improvement in four weeks following the completion of her physical therapy. Id.

Continued Medical Treatment

Petitioner returned to Dr. Tonino in August 25, 2014, October 6, 2014 and December 11, 2014 complaining of pain at night when her knee was flexed, while sitting for long periods of time and when ascending and, particularly, descending stairs. PX6 at 100-118. Dr. Tonino administered injections, which Petitioner reported were not effective. Id. He prescribed a new MRI. Id. Also, during these months of treatment, Dr. Tonino kept Petitioner off work or restricted to sedentary activities. PX6 at 129-133.

Petitioner underwent the recommended MRI on January 9, 2015 and returned to see Dr. Tonino for the last time on February 2, 2015. PX6 at 119-126; Tr. at 43. He reviewed the MRI which showed a possible partial tear of the PCL and mild patellofemoral arthritis, which was consistent with what he saw during surgery. Id. Dr. Tonino noted that no surgery was needed at that time and he placed her on a home exercise program. Id. He also released Petitioner back to work, but indicated that she should get up and walk around every once in a while which he believed she could do in a secretarial/ administrative position. Id. He scheduled a follow up visit in six weeks, however Petitioner did not return to see Dr. Tonino. Id.

Petitioner testified that Dr. Tonino did not release her from his care at this time. Tr. at 44. During some of the prior visits, he had done some injections and wanted to see how that would help, but then after that February visit, she tried to schedule appointments to see him, but every time she tried to go there the insurance company would call her and tell her that the visit was not authorized. Id. Petitioner also testified that she underwent another injection on February 2, 2015. Tr. at 87. Payments made by Respondent suggest that she did undergo an injection, but the medical records do not note such treatment. RX1.

Sixth Section 12 Examination & AMA Guides Impairment Rating – Dr. Cole

Respondent scheduled a sixth and final evaluation with Dr. Cole on March 30, 2015. RX3. Dr. Cole noted that Petitioner's report of continued pain, mainly posterolaterally around the biceps femoris site, even at rest and especially with knee flexion and extension. Id. Dr. Cole noted Petitioner's lower extremity functional score to be 24/80 including significant pain with many activities and a "relatively high level of impairment." Id. On examination, Dr. Cole noted full range of motion, no swelling/effusion, ligamentous stability and that Petitioner was neurovascularly intact. Id. He diagnosed Petitioner with left knee bicep femoral tendinitis with resolved

left knee pain. Id. Ultimately, Dr. Cole opined that no additional treatment was necessary, encouraged Petitioner to continue with a home exercise program and placed her at maximum medical improvement. Id.

Dr. Cole also evaluated Petitioner and provided a 0% impairment rating of the left knee/lower extremity utilizing the 6th Edition AMA Guides. RX3.

Petitioner testified that her visits with Dr. Cole were very, very short. Tr. at 45. She explained that he never even lifted up her leg to see how much she could bend it or not bend it, but he would ask her to walk five feet then turn around and walk back. Id. Petitioner testified that he never went into detail regarding her job. Id.

Additional Information

Petitioner also testified that she has searched for employment on her own over the past two years or so. Tr. at 52-53. She maintained a list of jobs to which she applied. PX9.

Prior to her injury at work, Petitioner described a very active lifestyle. Tr. at 57. She had been a part of health clubs and used to run up stairs to toboggan slides, for example. Id. She also has three boys which whom she was very active every year engaging in activities such as hiking, rock climbing, skiing, etc. Tr. at 57-58. Regarding her current condition, Petitioner testified that she is frustrated, depressed, and overweight by 16 pounds. Tr. at 58. Petitioner explained that she had always taken care of herself and was very healthy and active whereas now she cannot engage in certain sexual activities, run, kneel, sit for more than an hour or squat. Tr. at 58-60.

Michael Lynch

Michael Lynch (Mr. Lynch) was called as a witness by Respondent. Tr. at 99. He testified that he is employed by Respondent as its Treasurer since July 6, 2011. Id. He is responsible for all accounting and office activities. Tr. at 99-100. Petitioner reported to him while she was employed for Respondent. Tr. at 100.

According to Mr. Lynch, Petitioner's job duties as a billing coordinator were basically as Petitioner had described. Tr. at 101. Initially Petitioner was also performing payroll functions, but then Mr. Lynch took that over, as he is a certified accountant. Id. Then, Petitioner was doing "permit-ing," data entry and customer service. Id. She would also place meter readings into a box that were collected once every 3-4 months because most meter readings came in electronically and the paper readings did not fill up a whole box. Tr. at 101-102. He explained that Petitioner did not really have a physical job. Id.

Mr. Lynch testified about a summary of Petitioner's attendance records showing the full eight hour days that she worked and any deviations. RX2; Tr. at 103-105. Mr. Lynch testified that if Petitioner had not been terminated for reasons unrelated to her accident at work, Respondent would have accommodated her in a sedentary position with the various imposed restrictions of ambulation, bending, elevation, et cetera. Tr. at 107.

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 the hearing as follows:

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

The Arbitrator finds that Petitioner's claimed current condition of ill-being in the left knee is causally related to the injury sustained at work. In so finding, the Arbitrator notes the consistency of Petitioner's testimony with the medical records, and relies on the medical records of Petitioner's treating physicians, Drs. Regan and Tonino. Moreover, the opinions of Respondent's Section 12 examiner, Dr. Cole, support a finding of causal connection. While Dr. Cole disagreed with Petitioner's treating physicians about Petitioner's ability to perform the full duties of her position as a billing coordinator, he specifically related Petitioner's ongoing symptoms and the objective medical evidence that he reviewed over no less than six medical evaluations to Petitioner's injury at work. Thus, the Arbitrator finds that Petitioner's current condition of ill-being in the left knee is causally related to the injury sustained at work on November 10, 2011.

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

In light of the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that she is entitled to temporary total disability benefits for the period beginning November 11, 2011 through November 20, 2011 and from November 29, 2012 through March 30, 2015.

"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 (3rd Dist. 2014); *Matuszcak v. Ill. Workers' Comp. Comm'n*, 2014 IL App (2d) 130532 (2nd Dist. 2014); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that he was unable to work*. *Gallentine*, 201 Ill. App. 3d at 887 (*emphasis* added); *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

Respondent offers the opinions of Dr. Cole in support of its position that Petitioner is not entitled to the entirety of the benefits period claimed. However, Petitioner's testimony and the medical records reflect that she was incapacitated as a result of her injury at work such that she was either placed off work or on sedentary work restrictions which Respondent could not accommodate during the claimed temporary total disability period. Petitioner's last medical evaluation by any physician was with Dr. Cole, Respondent's Section 12 examiner, on March 30, 2015. Dr. Cole placed Petitioner at maximum medical improvement on this date, and Petitioner had no further medical treatment after her last visit with Dr. Tonino on February 2, 2015.

Dr. Cole's opinions regarding Petitioner's ability to perform the full duties of her job as described at trial are unpersuasive. Indeed, he understood that Petitioner's work was primarily sedentary and indicated on February 7, 2013 that Petitioner could work full duty but "[t]his is not to suggest that she would not have subjective

discomfort in working this full-duty job; however, I am stating that she is orthopaedically safe to do so, and she would not endanger, worsen, or progress the condition of her left knee if she were to work on the knee and use it full duty, with no restrictions." RX3. A few months later, Dr. Cole opined that an updated MRI to rule out pathology in Petitioner's knee would be reasonable, as would be a cortisone injection, but maintained that Petitioner could work without restrictions.

Dr. Cole's reports over six separate evaluations of Petitioner and her ongoing symptoms reveal that he agreed that Petitioner's left knee condition was related to her injury at work requiring additional diagnostic testing and medical treatment, but he disagreed with the treatment modalities recommended by Dr. Regan and Dr. Tonino. Given the totality of the record, the Arbitrator finds the medical records to support Petitioner's treating physicians' recommendations as reasonable particularly given Dr. Cole's corroborating findings during several examinations at Respondent's request. Petitioner was placed off work or on sedentary work restrictions, which would have allowed her to perform most, but not all, of her duties at work. Indeed, on cross examination, Petitioner testified that while she was working for Respondent she was accommodated and allowed to adjust her leg as needed as well as by other employees who assisted her in performing the billing functions that she could not perform. Petitioner's medical condition had not yet stabilized until she concluded her medical treatment with Dr. Tonino and last saw Dr. Cole on March 30, 2015.

Based on all of the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from November 11, 2011 through November 20, 2011 and from November 29, 2012 through March 30, 2015. Respondent shall be entitled to a credit for temporary total disability benefits that have been paid totaling $16,344.88.

Next, the Arbitrator addresses Petitioner's claim to maintenance benefits beginning April 1, 2015 through February 26, 2016. "Maintenance is awarded incidental to vocational rehabilitation." *Interstate Scaffolding v. Ill. Workers' Comp. Comm'n*, 385 Ill.App.3d 1040, 1049 (3rd Dist. 2008). Section 8(a) of the Act provides for an award of maintenance benefits while an employee is engaged in a prescribed rehabilitation program. *Nascote Indus. v. Indus. Comm'n (Berry)*, 353 Ill. App. 3d 1067, 1075 (5th Dist. 2004); *Connell v. Industrial Comm'n*, 170 Ill. App. 3d 49, 55 (1988)). There is also no prohibition against claimant-created and directed vocational rehabilitation programs, although they are disfavored. *Roper Contracting v. Industrial Comm'n*, 349 Ill. App. 3d 500, 505-506 (5th Dist. 2004).

Petitioner asserts that she conducted the required job search in fields where she had experience, such as sales and real estate, but has as of yet been unsuccessful in finding a position. Respondent asserts that Petitioner was at maximum medical improvement as opined by Dr. Cole and that she is not entitled to any maintenance benefits. As explained above, the Arbitrator does not find the opinions of Dr. Cole, that Petitioner was always able to perform the full duties of her job, to be persuasive. However, in the context of Petitioner's claim for maintenance benefits a close examination of her own treating physician's recommendations compared to her testimony is important. Particularly as there is no evidence in this case regarding whether Petitioner requested vocational rehabilitation services or whether Respondent prepare a written assessment pursuant to 50 Ill. Admin. Code § 7110.10; rather, the evidence reflects that Petitioner engaged in a self-directed job search and Mr. Lynch's testimony that, had Petitioner not been terminated for reasons unrelated to her injury, Respondent would have had work for her.

As of Petitioner's last visit with Dr. Tonino on February 2, 2015, he released her back to work. He did not impose specific or permanent restrictions. Rather, he indicated that Petitioner should be able to get up and walk around every once in a while and he added that he believed that she could do so in a secretarial/administrative position. While Petitioner maintains that she cannot perform all of the functions of her position as a billing

coordinator, she described the physical requirements of her position at length at the hearing. She explained the bending, squatting and lifting activities which according to her were part and parcel of her duties. She also explained that in her position she was sitting down approximately 70% of the time with the remaining 30% of her time spent running around getting meter readings and performing tasks such as billing, filing, pulling permits, covering for other employees at lunch, etc. While Petitioner maintains that there were bending, squatting and lifting activities in her job that she felt she was unable to perform, she also described the accommodations that she made herself (i.e., propping her leg up on a pillow on her computer tower, getting up and walking every so often throughout the day) while working after her accident but before her first surgery. These activities adjustments are similar, if not identical, to those recommended by Dr. Tonino on February 2, 2015.

Thus, in light of the record as a whole, the Arbitrator finds that Petitioner has failed to establish her entitlement to maintenance benefits as claimed. Petitioner's claim for such benefits is denied.

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

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at the hearing, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Respondent offered an impairment rating report from Dr. Cole into evidence. Dr. Cole determined that Petitioner sustained 0% impairment to the left knee/lower extremity. The Arbitrator therefore assigns significant weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a full time Billing Coordinator at the time of her accident and had been so employed by Respondent for years. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner testified that she was accommodated by Respondent during the periods that she worked after her accident. Petitioner's description of her own accommodations (i.e., propping her leg up on a pillow on her computer tower, getting up and walking every so often, etc.) as well as those made by her co-workers are similar if not identical to the last recommendations made by Dr. Tonino regarding Petitioner's ability to work on February 2, 2015. At that last visit, Dr. Tonino released Petitioner back to work, but indicated that she should get up and walk around every once in a while which he believed she could do in a secretarial/administrative position. Based on the evidence as a whole, the Arbitrator finds that Petitioner has failed to establish an earnings impairment as indicated by her own physician and the testimony of Mr. Lynch that Petitioner could have returned back to her job in the absence of her termination for reasons unrelated to her injury at work. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner underwent two surgeries to the left knee. Throughout her medical treatment, Petitioner was evaluated by Dr. Cole at Respondent's request and he agreed that Petitioner required ongoing medical treatment as indicated in his reports over the large part of his examinations in relation to her injury at work. Petitioner credibly testified about her ongoing symptoms and the activities in which she can no longer engage at all or for any length of time as a result of her left knee injury. Petitioner's testimony about this ongoing condition of ill-being in the left knee is buttressed by the treating medical records as well as her reports to Dr. Cole and his findings overall. As a result, the Arbitrator gives significant weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 30% loss of use of the left leg (knee) pursuant to §8(e) of the Act.

In support of the Arbitrator's decision relating to Issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Given the facts presented in this case, and after considering Petitioner's motion and Respondent's response, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner's injury and inability to work was as alleged. Respondent repeatedly required Petitioner to submit to Section 12 examinations throughout her treatment to this end. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

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

Kathy Sanders,

Petitioner,

vs. NO: 14 WC 133

18IWCC0449

State of Illinois - DHFS
Child Support Division,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 11, 2017, is hereby affirmed and adopted.

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

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

JUL 19 2018

DATED:
TJT:yl
o 7/16/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SANDERS, KATHY
Employee/Petitioner

Case# **14WC000133**

SOI/DCHF CHILD SUPPORT DIVISION
Employer/Respondent

18IWCC0449

On 4/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

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

APR 11 2017

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

18IWCC0449

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

KATHY SANDERS
Employee/Petitioner

v.

STATE OF ILLINOIS/DHFS CHILD SUPPORT DIVISION
Employer/Respondent

Case # 14 WC 00133

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 25, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0449

FINDINGS

On **December 9 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,091.00**; the average weekly wage was **$1,097.91**.

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

Respondent shall be given a credit of **$beneftis paid prior to 10/28/15** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$benefits paid prior to 10/28/15**.

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 right shoulder is causally related to her accident at work on December 9, 2013. Petitioner reached maximum medical improvement for both her right shoulder and her cervical spine on July 18, 2016.

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibit 1 that remain unpaid, except for those itemized in the Arbitration Decision, pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall be given a 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 under Section 8(j).

Respondent shall pay Petitioner temporary total disability benefits of **$731.94** per week for **6 3/7 weeks**, for the period of November 23, 2015, through January 7, 2016, for a total of **$4,705.34**.

Respondent shall pay Petitioner the sum of **$658.78**/week for a further period of **112.50 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused a **22.5% 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

April 7, 2017
Date

APR 11 2017

18IWCC0449

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KATHY SANDERS
Employee/Petitioner

v.

Case #: 14 WC 00133

STATE OF ILLINOIS/DHFS CHILD SUPPORT DIVISION
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Procedural History

This case was previously tried before a different Arbitrator on September 10, 2014, pursuant to Section 19(b) of the Act on the issues of accident, causation, liability for past and prospective medical benefits, and liability for temporary total disability benefits. Findings were in favor of Petitioner and the Commission affirmed and adopted the Arbitration Decision. PX16. The Arbitrator hereby acknowledges and incorporates herein the prior Arbitration Decision and Commission Decision and Opinion on Review.

Issues in Dispute

The current issues in dispute are causation with respect to Petitioner's right shoulder, past medical treatment to her right shoulder, temporary total disability benefits, and the nature and extent of Petitioner's permanent partial disability.

On December 9, 2013, the date of accident, Petitioner was 52 years old, single, and had no dependent children. She was a Child Support Specialist I for Respondent and had been so employed for about two years. She started with the Department of Corrections in 1999 and transferred to Child Support Services in 2000. According to the first Arbitration Decision, and by way of background only, Petitioner was injured when two heavy banker-type boxes fell on her, one from her right and one from her left. Both were situated above her head, on the top of two stacks of boxes which were five or six boxes high. She estimated they weighed 20 to 30 pounds each and they knocked her to the ground. She sustained injury to her neck, upper back, and right shoulder. She completed an Employee's Notice of Injury on December 22, 2013, with the above information, which was admitted into evidence at the first hearing. It was also admitted at the present hearing as Petitioner's Exhibit 13.

Subsequent to the initial hearing, Petitioner continued to treat with Dr. Gornet, and consistently reported symptoms of pain in her neck, right trapezius, and right shoulder, pain down the back of her right arm, numbness and weakness in her right arm, and headaches. She reported these symptoms to her other physicians as well, as follows and as documented in Petitioner's Exhibits 3, 5, and 8.

1. 11/12/14 Dr. Hays
2. 12/4/14 Dr. Gornet
3. 12/16/14 Dr. Boutwell
4. 1/16/15 Dr. Boutwell
5. 2/9/15 Dr. Gornet
6. 3/17/15 Dr. Boutwell
7. 4/9/15 Dr. Gornet
8. 5/12/15 Dr. Boutwell
9. 6/18/15 Dr. Gornet

On July 14, 2015, Petitioner underwent surgery by Dr. Gornet consisting of a two-level disc replacement at C5-6 and C6-7. PX5, PX10, PX11.

Petitioner followed up with Dr. Gornet on August 3 and August 27, 2015. She reported she was doing well but had some soreness. She remained off work. She next saw Dr. Gornet on October 26, 2015, at which time he noted that she continued to have the same right shoulder symptoms which were present prior to the cervical surgery. He stated, "Her exam still shows some focal issues that may be present in her shoulder and obviously the shoulder area is an overlap, which could have symptoms radiating from the shoulder itself versus being referred from the cervical spine." He believed these symptoms were causally connected to Petitioner's accident and he referred her to Dr. Lyndon Gross for evaluation of the right shoulder. He released Petitioner to return to light duty work with regard to her cervical spine as of October 26, 2015. She was not to lift more than 25 pounds or perform overhead work. PX5.

On October 26, 2015, Petitioner presented to Dr. Gross upon referral by Dr. Gornet. She reported a consistent history of the accident, stating a box above her fell and hit her on the head, neck, and posterior aspect of her right shoulder. Dr. Gross reviewed records from Dr. Gornet, which noted on January 3, 2014, that she complained of neck pain, headaches, and pain in the right trapezius, right scapula, and right shoulder. She continued to complain of pain in the posterior aspect of her shoulder, which was worse with activity. Dr. Gross noted he had previously treated Petitioner for a left shoulder problem, for which she had undergone surgical repair of a labral tear and subacromial decompression on October 28, 2011, with an excellent result. After a thorough examination, Dr. Gross opined that she had a strain of the scapulothoracic joint and he recommended conservative treatment of a corticosteroid injection and physical therapy. He allowed Petitioner to return to light duty work with respect to her right shoulder. She was not to lift more than 25 pounds below shoulder level and no lifting above shoulder level. PX12. The steroid injection was performed that day by Dr. Helen Blake. PX8.

Petitioner returned to Dr. Gross on November 23, 2015, and reported that the injection did not give her any significant improvement. She continued to complain of pain over the superior, anterior, and posterior aspects of her shoulder, with the posterior pain being the worst.

After an examination, Dr. Gross noted she had more pain in the scapulothoracic joint area but also had pain over both the superior aspect of the shoulder, in the area of the AC joint, and the anterior aspect of the shoulder, in the area of her rotator cuff and biceps tendon. He opined that her ongoing symptoms were causally related to the blunt trauma to her shoulder and neck area. Due to her continued complaints, Dr. Gross ordered an MRI arthrogram. Petitioner was allowed to work light duty, with no use of her right arm. PX12.

On December 3, 2015, Petitioner underwent the MRI arthrogram which revealed supraspinatus tendinosis, type III acromion process, and mild acromioclavicular degeneration. There was no evidence of a supraspinatus tear or a glenoid labral tear. PX6. Petitioner also underwent subacromial bursa and AC joint injections that day. PX8.

On January 7, 2016, Petitioner returned to Dr. Gross and reported the recent injections helped with the pain and she was able to do her physical therapy. She still had occasional soreness but overall felt she was improved. She was released to return to work regular duty with respect to her shoulder, but Dr. Gross noted she still had restrictions from Dr. Gornet with respect to her cervical spine. He released Petitioner from care at that time. PX12.

On January 21, 2016, Petitioner was re-examined by Respondent's Section 12 physician, Dr. James Emanuel. He had previously seen her on April 24, 2014, and had opined that Petitoner's cervical complaints were related to her work accident but that her shoulder complaints were not. His previous opinion, which was admitted at the original hearing on September 10, 2014, was that the work injury did not alter the natural course of Petitoner's underlying shoulder condition. He opined that she had reached maximum medical improvement and had sustained no permanent partial disability with regard to her right shoulder. RX1.

At the second evaluation, Dr. Emanuel reviewed treatment records subsequent to his first evaluation, performed an examination, and stated that his opinion with regard to causation of the right shoulder complaints had not changed. RX2. He reiterated his opinions when he testified by way of a second deposition on March 29, 2016. He acknowledged on cross-examination, however, that Petitioner had complained of shoulder pain when she presented to the hospital shortly after the accident and that x-rays of the shoulder were taken at that time. RX3.

On January 28, 2016, Petitioner followed up with Dr. Gornet, six months post-cervical disc replacement surgery. He noted she had come a long way and he was very pleased with her progress. He released her to return to work full duty with no restrictions at that time. PX5.

Petitioner returned to Dr. Gornet on April 28, 2016, and reported that her neck was doing well and that, for the most part, her shoulder was doing well. She still had mild pain in the shoulder and it was noted she may require further injection. She was working full duty. She followed up with Dr. Gornet on July 18, 2016, and again reported she was doing well with her neck but still had pain in her right shoulder. She underwent AC joint and subacromial bursa injections by Dr. Blake that day, then returned to Dr. Gornet. She reported the injections gave her tremendous relief, which led Dr. Gornet to believe that her continued symptoms were related to the shoulder and not her neck. He placed Petitioner at maximum medical improvement for her

neck and instructed her to follow up in one year, and to advise if she continued to have shoulder problems. The Arbitrator notes this is the last treatment record. PX5, PX8.

Dr. Gross testified by way of deposition on July 19, 2016. He is a Board Certified Orthopedic Surgeon with a subspecialty certification in Sports Medicine. He testified consistent with his treating records that Petitioner developed scapulothoracic joint/bursitis problems secondary to being struck by a box in that area. He testified that the injections he recommended for Petitioner served both a diagnostic and a therapeutic function, and that Petitioner's positive response to the last injection into the AC joint and subacromial space confirmed this was the area producing her symptoms. He testified that he and Dr. Emanuel essentially agreed on what was wrong with Petitioner, but differed in their opinions with regard to the causal relationship to Petitioner's work accident of December 9, 2013. Dr. Gross testified that the accident aggravated her underlying problems in addition to causing some scapulothoracic bursitis. He based his opinion on the mechanism of the injury and her consistent complaints of neck, shoulder, and arm pain. Following cervical surgery her shoulder complaints persisted and it was appropriate to address the complaints at that time. PX15.

On cross-examination, Dr. Gross agreed that it was possible that when he saw Petitioner approximately two years after her accident that she had simply experienced a natural progression of her underlying degenerative condition. He testified that the aggravation of her degenerative condition was temporary, since she had gotten better with treatment. PX15.

Petitioner testified at the final hearing in this matter on August 25, 2016. She confirmed all of the treatment that had taken place since the initial hearing, as detailed above. She still experiences soreness in her neck following a full day of activities, work, chores, reaching in front of her or above her head, and lifting heavy items. Her range of motion in her right arm is affected when she tries to do things with her arms out in front of her or lifted above her head. The strength in her right arm is about 70% of what it was. She testified that in her job as a Child Support Specialist she is required to lift files and boxes. She testified that her hobbies of competitive barrel racing and horse training had been adversely affected and that she had completely given up competitive barrel racing as of August 2013. She has not tried to race since then because she does not have enough strength in her upper body or in the grip of her hands. She testified she still owns horses and takes care of them with the help of her family. She does not currently take prescription pain medication, but takes Ibuprofen or Tylenol and uses hot and cold packs once or twice a week.

On cross-examination, Petitioner agreed that the last time she saw Dr. Gross was on January 7, 2016, and that her examination at that time showed she had 5/5 strength and that her forward flexion and abduction was 180 degrees. She conceded that she had stopped competitively barrel racing prior to her accident. She further conceded that caring for her horses involves lifting heavier items than those encountered at work. She acknowledged that she had returned to work fully duty and was able to perform all aspects of her job. She testified that she currently earns the same money as she did prior to her accident.

CONCLUSIONS OF LAW

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

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

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

The parties' current dispute with regard to causation is only as to her right shoulder. The Arbitrator finds Petitioner's condition of ill-being with regard to her right shoulder is causally related to her work accident of December 9, 2013. In so concluding, the Arbitrator finds that the rule of the law of the case applies. In addition, the Arbitrator finds that the chain of causation was not broken, as the record is consistent throughout with regard to Petitioner's complaints and objective findings, which started immediately after the accident.

The rule of the law of the case is a rule of practice, based upon sound policy that, where an issue is once litigated and decided, that should be the end of the matter and the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. *Irizarry v. Industrial Comm'n*, 337 Ill.App.3d 598, 606 (2nd Dist. 2003) (citing *McDonald's Corp. v. Vittorio Ricci Chicago, Inc.*, 125 Ill.App.3d 1083, 1086-1087 (1st Dist. 1984). The law of the case doctrine is applicable to issues litigated before the Illinois Workers' Compensation Commission. *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill.App3d 244, 252 (1st Dist. 2008).

The Arbitrator notes that the initial hearing pursuant to Section 19(b) was held on September 10, 2014, and the Arbitration Decision was issued on October 8, 2014. Respondent filed a Petition for Review, and on May 19, 2015, the Commission issued its decision affirming and adopting the Arbitration Decision. No further appeal was taken and Petitioner's case was eventually remanded to the Arbitrator.

Following the initial hearing, the Arbitrator specifically found that, with regard to accident, "Two boxes full of files fell striking her head, neck, and right shoulder." With regard to the issue of causal connection, although the focus at that time was primarily on the cervical complaints and proposed cervical surgery, evidence admitted at trial and considered by the Arbitrator included medical records which documented Petitioner's right shoulder complaints. He specifically discussed and considered the report and deposition testimony of Dr. Emanuel, and noted Dr. Emanuel's opinion that Petitioner did not sustain an injury to her right shoulder as

a result of the accident. On the issue of causal connection he stated, "Given the above findings, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work accident of December 9, 2013." Although his finding did not list the body parts included in the causation ruling, his finding with regard to accident did, as noted above ("head, neck, and right shoulder"). He had the opportunity to specifically parse out the right shoulder as not being causally related, and he did not do so. As such, the rule of the law of the case applies and the conclusions from the first arbitration hearing in this case are binding.

In the most recent hearing, both parties presented evidence of medical treatment rendered subsequent to the first hearing. Recognizing the two-year lapse of time between the hearings, this Arbitrator evaluated the subsequent records to determine if the chain of causation had been broken, by virtue of an intervening accident, a large gap in time without shoulder complaints, or the like. The Arbitrator finds that no such break in the chain of causation occurred.

Petitioner first sought medical treatment the day after the accident. She reported to Dr. Hays that several boxes had fallen on her, striking her in the back of the neck, *right shoulder*, and mid back. She continued to consistently report symptoms of pain in her neck, *right trapezius*, and *right shoulder*, pain down the back of her right arm, numbness and weakness in her right arm, and headaches. She reported these symptoms to virtually every physician she saw prior to being referred to Dr. Gross, as documented in Petitioner's Exhibits 3, 5, 7, and 8, and Respondent's Exhibit 1 as follows.

1. 1/3/14 Dr. Gornet
2. 1/21/14 Dr. Granberg
3. 2/11/14 Dr. Granberg
4. 4/24/14 Dr. Emanuel
5. 6/5/14 Dr. Gornet
6. 11/12/14 Dr. Hays
7. 12/4/14 Dr. Gornet
8. 12/16/14 Dr. Boutwell
9. 1/16/15 Dr. Boutwell
10. 2/9/15 Dr. Gornet
11. 3/17/15 Dr. Boutwell
12. 4/9/15 Dr. Gornet
13. 5/12/15 Dr. Boutwell
14. 6/18/15 Dr. Gornet

The record is clear that Petitioner's shoulder complaints were consistent and uninterrupted from the date of accident through the duration of her treatment, and specifically so following the initial hearing on September 10, 2014. Dr. Gross, though agreeing there was degeneration present, also recognized the consistent complaints and mechanism of the injury, and opined that the accident temporarily aggravated Petitioner's pre-existing degeneration. On this point, the Arbitrator finds Dr. Gross to be persuasive and further finds the chain of causation was not broken.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner met her burden of proof on the issue of causal connection with respect to her right shoulder. The

Arbitrator further finds that Petitioner reached maximum medical improvement with regard to both her right shoulder and her cervical spine on July 18, 2016, that being the last treatment.

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

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of 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).

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered for treatment to Petitioner's right shoulder were reasonable and necessary relative to her accident of December 9, 2013. Respondent is liable for the outstanding medical bills as set forth in Petitioner's Exhibit 1, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act, with the exception of those itemized below. Respondent shall receive credit for amounts previously paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. The parties stipulated that all medical bills awarded shall be paid directly to the medical providers.

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

1. Dr. Matthew Gornet/The Orthopedic Center 1/3/14-7/20/16, 12 charges @ $33/visit	$396.00
2. Drs. Boutwell & Blake/Pain & Rehabilitation Specialists 12/16/14-7/18/16, 7 charges @ $35/visit	$245.00
3. Dr. Lyndon Gross/The Orthopedic Center 10/26/15-1/7/16, 4 charges @ $40/visit	$160.00
TOTAL	**$801.00**

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

In order to be eligible for temporary total disability benefits, a claimant must prove note only that he did not work, but also that he was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill.App.3d 1087, 1090 (5th Dist. 1990). 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, 887 (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*, 344 Ill.App.3d 752, 760 (4th Dist. 2003).

The parties stipulated that Respondent had paid all appropriate temporary total disability prior to October 28, 2015. Petitioner alleges she is entitled to an additional period of TTD from November 23, 2015, through January 7, 2016, a total of 6 3/7 weeks.

The record shows that both Dr. Gornet and Dr. Gross placed Petitioner on light duty work. Dr. Gornet had her on light duty restrictions from October 26, 2015, until January 28, 2016. Dr. Gross also had her on light duty from October 26, 2015, until January 7, 2016.

The record establishes that Petitioner was on light duty restrictions from October 26, 2015, until her full release on January 28, 2016. This period of time does not match the period being claimed by Petitioner, and the record does not provide an explanation for the difference. It is possible she was allowed to work with restrictions during some of that period, and thus not entitled to TTD, but that is speculative. The Arbitrator must rely upon Petitioner's assertions as to the appropriate period being claimed.

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from November 23, 2015, through January 7, 2016, a total of 6 3/7 weeks. The parties stipulated that Petitioner's average weekly wage was $1,097.91, and the Arbitrator finds her TTD rate was $731.94. Respondent is liable for temporary total disability benefits of $4,705.34.

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

With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section 8.1b 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 this accident was after the effective date of Section 8.1 b of the Act, neither party offered into evidence a reported level of impairment pursuant to subsection (a). As such, the Arbitrator gives no weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Child Support Specialist at the time of the accident and that she was able to return to that position without restrictions as a result of said injury. Petitioner testified that as part of her job she has to lift and move large files, and about once a month she also moves boxes that weigh up to 50 pounds. These activities aggravate her symptoms. The Arbitrator notes, however, that Petitioner testified she owns, rides, and cares for horses and that the care of the horses involves lifting heavier items than those she lifts occasionally at work. The Arbitrator gives some weight to this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 52 years old at the time of the accident and 55 at the time of hearing. She was able to return to

her prior position without limitation. She testified she will work another five years before retiring. Over the coming years her condition could improve, stay the same, or get worse. There was no evidence offered to indicate with any degree of likelihood how her age would impact her disability, and the Arbitrator declines to speculate as to same. The Arbitrator gives some weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner returned to her prior position full duty at the same rate of pay. Neither party offered any evidence to show that Petitioner's future earning capacity has been impacted, and the Arbitrator has no basis to expect she will have any decreased earning capacity in the future. The Arbitrator gives no weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes that Petitioner sustained injuries to her neck, upper back, and right shoulder. She underwent a two-level cervical disc replacement surgery and several injections into her right shoulder. Her complaints and injuries are well-documented in the medical records throughout her treatment. She testified she still continues to have soreness in her neck, which is aggravated by her work activities and household chores that involve reaching outward and overhead. She testified her job requires her to lift heavy files and, about once a month, boxes that can weigh up to 50 pounds. However, the Arbitrator notes that Petitioner conceded on cross-examination that caring for her horses involves lifting items that are heavier than those encountered at work. She testified she has guarded range of motion in her right shoulder and has difficulty lifting and/or performing overhead activities. Dr. Gornet's note following Petitioner's final visit of July 18, 2016, documents she was doing well with her neck but still having some right shoulder pain. She received shoulder injections that day, which gave her tremendous relief. 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 22.5% loss of use of the person as a whole (112.50 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $1,097.91. The Arbitrator finds that her permanent partial disability rate is $658.78.

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

JIM JERNSTAD,

Petitioner,

vs.

NO: 15 WC 20895

BLACK HORSE CARRIERS,

18IWCC0450

Respondent,

DECISION AND OPINION ON REVIEW

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

In the Order section, the Arbitrator wrote, Respondent "shall authorize and pay for" prospective medical care. We clarify that this should be stated as "shall provide and pay for".

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed is hereby affirmed and adopted with the clarification noted above.

18IWCC0450

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 $10,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 19 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 6/27/18
49

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

JERNSTAD, JIM
Employee/Petitioner

Case# **15WC020895**

BLACK HORSE CARRIERS
Employer/Respondent

18IWCC0450

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

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

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

5614 LAW OFFICE OF CAMERON CLARK PC
203 N LASALLE ST
SUITE 2100
CHICAGO, IL 60601

1682 HINSHAW & CULBERTSON
PETER H CARLSON
222 N LASALLE ST SUITE 300
CHICAGO, IL 60601

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)

18IWCC0450

Jim Jernstad
Employee/Petitioner

v.

Black Horse Carriers
Employer/Respondent

Case # 15 WC 20895

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 **Wheaton**, on **October 25, 2016; proofs were closed on November 7, 2016 in Geneva.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0450

On the date of accident, **July 25, 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 $**67,600.00**; the average weekly wage was $**1,300.00**.

On the date of accident, Petitioner was **64** years of age, **married** with **0** dependent children.

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and Credit, per stipulation of the parties for medical bills paid through its group medical provider.

ORDER

The Respondent shall pay the further sum of $10,787.85 for necessary medical services, as provided in Section 8(a) of the Act, to be paid pursuant to the provisions of the Illinois Medical Fee Schedule. The parties stipulate that Respondent is entitled to any applicable credit under Section 8(j) of the Act. Respondent shall hold Petitioner safe and harmless from any claims made by the group insurance carrier or medical providers.

The Respondent shall authorize and pay for the prospective medical care in the form of the previously recommended surgery, as recommended by Dr. Ronjon Paul, for Petitioner's cervical condition.

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

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

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

Signature of Arbitrator

12/8/16
Date

DEC 12 2016

FINDINGS OF FACT

This case involves a Petitioner alleging that he was injured while working for the Respondent on July 25, 2014. Both parties stipulated to the following issues in dispute: 1) accident; 2) causation; 3) medical expenses; and 4) prospective medical care.

Petitioner testified that, on July 25, 2014, he was employed as a truck driver for Respondent. Petitioner had been employed in this capacity for approximately nine years prior to July 25, 2014. He had been previously employed with Respondent in the mid-90's, although it was doing business under a different name. Petitioner testified that his job duties as a truck driver required him to deliver groceries to Aldi Foods. He would drive one of Respondent's trucks, back up to the dock and use whatever equipment is available, including two pallet jacks or single pallet jack, and load pallets onto his truck. He would basically load the trailer with the groceries going to the Aldi store and proceed there. He would then unload the groceries and return back to the warehouse. Petitioner testified that his job would require him to lift upwards of 75 pounds.

Petitioner testified that, on July 25, 2014, he was performing his job duties as a truck driver for Respondent at the Aldi facility in Batavia, IL. He further testified that he reported to work to load up the first load to be delivered to an Aldi store. He started loading the trailer with a double pallet jack. Petitioner explained that this is the type of pallet jack that you stand on the back of and ride. While attempting to load groceries, Petitioner had a problem getting underneath the first pallet jack, so he attempted to wiggle it loose so it would go underneath the pallet. It abruptly loosened up and he flew underneath the second pallet and right behind the second pallet was a cement wall. Petitioner testified that the double pallet jack he was operating ran into the cement wall and he felt a jolt in his neck and movement of his body. He clarified that the front forks of the pallet jack are what struck the cement wall. Petitioner testified that after striking the wall, he did not fall off of the pallet jack. However, Petitioner testified that after striking the wall, he noticed soreness in his neck that was "quite sore" and that he was rubbing his neck at the time. Petitioner testified that he continued to complete his work shift that day.

Petitioner testified that, prior to July 25, 2014, he did sustain an injury involving his cervical spine. This injury occurred in the early 90's. The medical records entered into evidence document that Petitioner underwent a discectomy and cervical fusion of C5-6 and C6-7, by Dr. Lorenz. Petitioner was eventually discharged by Dr. Lorenz. Petitioner testified that from the time of his discharge from Dr. Lorenz in the mid-90's for his cervical injury up to July 25, 2014, he did not sustain any new injuries or accidents involving his cervical spine. Petitioner also testified that during this time period he was not receiving any active medical care on his cervical spine, nor had any physician ever recommend that he undergo a revision surgery on his cervical spine. The Petitioner did admit to subsequent accidents that he was involved in following his discharge from Dr. Lorenz. However, Petitioner testified that these accidents and subsequent medical treatment involved his lumbar spine, not his cervical spine.

Petitioner was also questioned regarding a possible incident or neck pain that he was suffering from in September of 2012. The medical note of Dr. Isoniemi from that date documents the following history: "Works nights. Woke up at 4pm yesterday with bad neck pain. Tried to take hot, soaking shower, with slight improvement. Went back to bed, woke up at 8pm, symptoms even worse. Tried getting ready for work, but was ge tting HA, neck pain, lightheadedness, near syncope, unlike his previous vertigo."(PX#1) Petitioner testified that he did not injure his neck at this time. Rather, Petitioner testified that he had been referred to an ear, nose, and throat physician. It was later determined that

Petitioner's symptoms were being caused by a piece of cotton that was lodged in his ear canal. Petitioner testified that following the removal of the cotton from his ear, his neck pain and other symptoms went away.

Petitioner testified that he eventually sought treatment for his cervical condition on July 26, 2014. On that date, Petitioner underwent x-ray studies of his cervical spine and was placed on Flexeril and a Medrol Dosepak. (PX#1) Petitioner had a follow up appointment with Dr. Isoniemi on July 30, 2014. The medical records note that Petitioner had a twisting whiplash injury at work when a forklift ran into a wall. It was also noted that Petitioner was feeling 90-95% better, finishing the Medrol Dosepak and taking ibuprofen. Petitioner was still experiencing pain that radiates into his left upper back. Following the July 30, 2014 examination, Dr. Isoniemi released Petitioner to return to work. He also recommended that he return, if his symptoms persisted.

Petitioner testified that he did return to work for Respondent. Following his return to work, Petitioner testified that he seemed okay following the medication for a while but it progressive got worse. Petitioner testified that he was experiencing more numbness and tingling on the left side of his neck into his shoulder. The symptoms progressively got worse as Petitioner worked each day and each week and each month.

Petitioner eventually returned to Dr. Isoniemi on December 8, 2014. Petitioner testified that during the time period from his return to work with Respondent on July 30, 2014 through the December 8, 2014 medical exam, that he did not sustain any new injuries or accidents involving his neck. He further testified that during the time frame of July 30, 2014 to December 8, 2014, his cervical and upper extremity pain never went away. The medical report from the December 8, 2014 examination documents the following: "Following up on neck pain. See last OV. Was in ER, end of July, cervical spine xrays normal. Symptoms largely resolved in first week with Medrol does pack. Notes ongoing pain, numbness tingling in both shoulders L>R since that time. Operates lift machine at work has to hold head turned to left for extended periods of time. Notes the tingling after about 15 seconds. Radiates to mid upper left arm." (PX#1) Following the examination of December 8, 2014, Dr. Isoniemi recommended that Petitioner undergo a cervical MRI study and return for follow up.

Petitioner underwent the recommended MRI study on December 16, 2014 at Diagnostic Imaging. Thereafter, Dr. Isoniemi noted on December 23, 2014, that the MRI showed that "the previous C5-C7 fusion looks good, but there are several herniated discs above and below the fusion, which are likely causing his symptoms. Next step is to get into the spine clinic to evaluate for possible cortisone injection and/or surgery." (PX#1) Petitioner testified that he was eventually referred to Dr. Ronjon Paul for evaluation.

Petitioner was initially examined by Dr. Paul on January 23, 2015. (PX#1) On that date, Petitioner completed an intake form. The intake form sets forth the reason for visit as "work comp injury"- "varied pain in back of neck upper and lower, burning and tingling feelings in left and right shoulders depending on length of days activities." Petitioner further set forth that his pain or problem began when he "hit cement wall with riding a standing pallet jack trying to get under pallets. It extended through the pallets and struck the wall and stopping abruptly, causing a severe jolt to my head and body while turned sideways, on the pallet jack." When asked: "how long have you had this problem?" Petitioner responded, "Since July 25, 2014, day of accident?" (PX#1) The medical report dated January 23, 2015 sets forth that Dr. Paul had carefully reviewed Petitioner's intake questionnaire before his encounter.

The report sets forth the following: "I had a long discussion with Jim Jernstad regarding his work-related injury. He states that on July 25, 2014, he had an abrupt accident where he hit a cement wall when riding a pallet jack. He had a previous cervical fusion done several years ago, but now he has had significant exacerbation in the neck, upper extremity pain, and radiculopathy. [. . .] He states he can work at this time. We will attempt to keep him working throughout this period. If his pain is refractory to nonoperative management, he may require a revision encompassing the C4-C5 level." (PX#1) Dr. Paul recommended that Petitioner undergo cervical injections and physical therapy.

Petitioner testified that he began the recommended physical therapy at ATI on February 2, 2015. He participated in therapy until approximately March 30, 2015. (PX#2) Petitioner also testified that he underwent the recommended cervical spine injection, under the direction of Dr. Paul Manganelli, on February 20, 2015. Thereafter, Petitioner attended a follow up appointment with Dr. Paul on March 13, 2015. Following this examination, Dr. Paul recommended that Petitioner under a revision fusion procedure including the C4-5 level. Petitioner also returned to Dr. Manganelli on March 13, 2015 to undergo a second cervical epidural steroid injection. (PX#1)

Petitioner testified that his cervical surgery was initially scheduled for May 15, 2015. This date was then rescheduled to June 18, 2015. Petitioner testified that during this time period he was scheduled, at the request of the workers' compensation insurance carrier, to attend a Section 12 examination with Dr. Robert Beatty on May 1, 2015. Petitioner attended that examination. Petitioner testified that he had also seen a copy of Dr. Beatty's report. Petitioner also testified that during his examination with Dr. Beatty, he did not tell the doctor that he has had recurrent neck attacks over the years. Petitioner said he had no idea of why that statement would be in the doctor's report.

Dr. Beatty testified via evidence deposition on February 17, 2016. Dr. Beatty opined that Petitioner sustained a flexion-extension injury to the neck on July 25, 2014 and that Petitioner's current diagnosis is not related to any injury of July 25, 2014. "He may have had a soft tissue injury with flexion-extension mechanism but those injuries have long ago healed at the most four months after the injury . . ." Dr. Beatty then stated that Petitioner "is a candidate for fusion at C4-5; however this fusion would not be related to the accident but is related to the degenerative process that has been going on for 19 years which has reached a point that it is giving him some pain." In his deposition, Dr. Beatty opined that Petitioner did experience a flexion/extension injury to his neck as a result of the July 25, 2014 accident from which Petitioner had fully recovered and returned to his "baseline" with respect to his whiplash injury on July 25, 2014. (RX#1, at Page 27). On cross-examination, Dr. Beatty testified that his report contained discrepancies in the alleged history provided by Petitioner regarding having neck complaints prior to July 25, 2014, and that it was his understanding from 1997 to 2005, that Petitioner had no neck problems. (RX#1, at Page 34). Dr. Beatty acknowledged that the records he reviewed from 2009 through November 2011, did not reflect any complaints of cervical pain by Petitioner. Dr. Beatty also confirmed that in his review of all the medical documentation, he did not see or review any medical record from any treatment that Petitioner had received prior to the accident of July 25, 2014, where Petitioner's doctor had recommended cervical surgery. (RX#1, at Page 39). Dr. Beatty opined that Petitioner did sustain a whiplash type injury to his cervical spine on July 25, 2014, which would be the type of mechanism that can aggravate what was a previously nonsymptomatic degenerative condition to become symptomatic. (RX#1, at Page 43-44). Dr. Beatty testified that an aggravation is a permanent worsening of a preexisting condition and, that an "exacerbation is a temporary worsening of a preexisting condition following a transient increase in symptoms, signs, disability. The person recovers to his or her baseline status or what it would have been had the exacerbation never occurred." Dr. Beatty further testified that it was

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only after the accident of July 25, 2014 that Petitioner had remained under an active course of medical care with his treating physicians for neck complaints, and had received a recommendation for surgery. (RX#1, at Pages 53-57).

Petitioner attended a pre-op physical on June 8, 2015. He also attended a follow up appointment with Dr. Paul on June 17, 2015. In this report, Dr. Paul opines and notes that Petitioner sustained a work-related injury. He also notes that he reviewed the MRI and that Petitioner does have an acute component with disk material at the C4-C5 level. Dr. Paul also opines that Petitioner had an acute exacerbation of his preexisting stenosis. Dr. Paul states: "I have reviewed the IME. There are some typos and factual errors. It is clear that he has had an acute on-the-job injury, which gave him significant neck and upper extremity pain at an adjacent level, not the same levels as his prior surgery. We will keep him off of work until we are to proceed with surgical intervention." (PX#1) Following the examination, Dr. Paul recommended a revision fusion procedure at the C4-C7 levels. (PX#1) Petitioner testified that he wishes to proceed with the recommended surgery. However, he has not yet been able to undergo the recommended surgery due to non-approval by the insurance carrier. Petitioner further testified that he has not returned to Dr. Paul since his visit of June 17, 2015, as Dr. Paul advised him to return once he was able to have the surgery.

Petitioner also testified that he had recently undergone a DOT exam as part of his employment with Respondent. The DOT physician report was entered into evidence by Respondent. This report documents that Petitioner disclosed his prior cervical surgery and noted current complaints of tingling and numbness in the left side of his shoulder and neck. He also noted occasional neck pain and soreness on the left side. Petitioner passed the DOT exam.

Petitioner entered into evidence various medical bills. Specifically, the following bills were admitted into evidence:

1. DuPage Medical Group (PX#3) – Total Charges $5,838.00; alleged outstanding amount of $2,712.13

2. Dr. Paul Manganelli (PX#3) – Total Charges $10,598.00; alleged outstanding amount of $8,075.72.

At the Arbitration hearing, the parties stipulated that, upon a finding for Petitioner, the medical bills would be payable pursuant to Section 8(a) and 8.2 of the Act.

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 unrebutted testimony and the medical evidence. Petitioner credibly testified that he experienced neck pain immediately following the incident of July 25, 2014. All of the medical records submitted into evidence corroborate Petitioner's history of the event and establish that he sustained an accidental injury on July 25, 2014. Additionally, Respondent's Section 12 physician opined that Petitioner sustained a whiplash type injury on July 25, 2014. There was no evidence presented to rebut Petitioner on this issue. Accordingly, the Arbitrator concludes that the Petitioner sustained an accident while working for the Respondent on July 25, 2014.

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2. Regarding the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. This finding is supported by the Petitioner's unrebutted testimony and the medical evidence. All of the Petitioner's medical evidence supports the Petitioner's claim that he sustained a cervical injury on July 25, 2014, which progressively worsened, to the point where Petitioner now needs surgical intervention. Although the Petitioner did have prior neck surgery in the 1990's, Petitioner credibly testified that he has not had any treatment from that prior surgery through the date of accident in the current case. The Arbitrator finds persuasive the opinion of Dr. Paul that Petitioner had an acute exacerbation of his preexisting stenosis, for which he now requires a revision fusion procedure. Respondent disputes this issue based on the opinions of its IME, Dr. Beatty, who opined that the Petitioner's condition of ill-being is attributed to a whiplash type injury, which would have resolved 3-4 months post accident date. Dr. Beatty's opinion that Petitioner's cervical condition was only temporarily exacerbated because he returned to his baseline condition is not supported by the evidence, which shows that the Petitioner continued to experience pain in his neck that worsened over time. Furthermore, Dr. Beatty acknowledged that a whiplash type injury could aggravate or permanently worsen what was a previously non-symptomatic degenerative condition to become symptomatic – which appears to be the Petitioner's case on point. There was no evidence presented of any intervening incident from the July 25, 2014 incident to the present that could have broken the chain of causation in this case. Based on this information, the Arbitrator concludes that the Petitioner's current condition of ill-being is causally related to his July 25, 2014 work accident.

3. Based on the Arbitrator's findings on the issues of accident and causation, the Arbitrator further finds that the medical treatment provided to Petitioner was reasonable and necessary. Respondent is liable for payment of the medical bills summarized previously in this decision, subject to adjustments consistent with the provisions of the Medical Fee Schedule, Section 8.2. The Arbitrator orders Respondent to calculate the exact amount of benefits owed to the various medical providers pursuant to Section 8.2. The parties agree that Respondent is entitled to any applicable 8(j) credit in that regard and that Respondent shall hold Petitioner safe and harmless from any claims made by his group health insurance carrier or from any medical providers whose bill was discharged by Petitioner's group health insurance carrier.

4. Based on the Arbitrator's findings above, the Arbitrator further finds that the Petitioner's request for prospective medical care related to this claim is both reasonable and necessary to treat his work-related cervical condition. The Arbitrator specifically awards Petitioner prospective medical care in the form of the recommended surgery, as prescribed by Dr. Paul.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT BLANKSHAIN,

Petitioner,

18IWCC0451

vs. NO: 08 WC 5480

WALSH CONSTRUCTION CO.,

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 vocational expenses, temporary total disability/maintenance, credit, prospective medical expenses, penalties and fees, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner was an ironworker who suffered a work-related accident on January 28, 2008. He eventually had four shoulder surgeries, two on his right shoulder and two on his left shoulder. He had a Functional Capacity Evaluation ("FCE") on April 9, 2010 which found him capable of functioning at the heavy physical demand level, but also that he had pain while functioning at that level. Petitioner's surgeon, Dr. Marra, released him to work with restrictions as outlined in the FCE.

After the accident, Petitioner enrolled at DePaul University and graduated with a degree in finance. He testified that he graduated with either a 3.99 or 4.0 GPA. He conducted a self-directed job search and then on May 10, 2011, Respondent hired a vocational counselor, Mr. Patsavas, to assist his job search. Respondent eventually terminated vocational rehabilitation services in early 2013 and Petitioner hired another vocational counselor, Mr. Gzresik, to review his job search efforts. The record shows that between July 26, 2013 and October 9, 2013, Petitioner played golf 21 times. Respondent submitted surveillance videos showing Petitioner engaged in rather extensive gardening activities.

The Arbitrator awarded Petitioner 169&4/7 weeks of temporary total disability/maintenance benefits, and 150 weeks of permanent partial disability benefits representing loss of 30% of the person-as-a-whole. The Arbitrator also noted that all medical expenses had been provided, he denied maintenance benefits from August 24, 2013 through April 15, 2015 and between November 1, 2014 through May 9, 2017, he denied compensation for wage differential and permanent total disability benefits, and denied reimbursement for Petitioner's college expenses. The Arbitrator awarded Respondent a total credit of $318,448.35 representing payment of $289,000.00 in temporary total disability/maintenance payments and $29,448.35 in advance payments of permanent partial disability benefits.

The Commission agrees with the Arbitrator's analysis and decision regarding the issues of temporary total disability/maintenance benefits, credit, denial of prospective medical, denial of penalties and fees, and denial of college expenses, and affirms and adopts those portions of the Decision of the Arbitrator. As noted above, the Arbitrator awarded Petitioner 150 weeks of permanent partial disability benefits representing loss of 30% of the person-as-a-whole. On review Petitioner seeks the Commission to find him permanently and totally disabled under the odd-lot theory of permanent disability based on his diligent but unsuccessful job search.

In arriving at his permanency award, the Arbitrator found that limitations Petitioner placed on his job search rendered it ineffective. He noted that Petitioner did not always accept the recommendations of Respondent's vocational rehabilitation counselor and excluded entire job categories for which he was qualified because he did not want to do physical labor. The Arbitrator correctly noted that "the intention of vocational rehabilitation is to return Petitioner to work not to return Petitioner to a new career of his choice." He also noted that Petitioner's vocational rehabilitation counselor opined that Petitioner would benefit from additional vocational services, indicating his belief that Petitioner was employable. The Arbitrator also found that the opinion of Dr. Aribindi, Respondent's Section 12 medical examiner, more persuasive than that of Petitioner's surgeon, Dr. Marra. Dr. Aribindi opined that Petitioner could return to work as an ironworker without restrictions, while Dr. Marra opined that he had to have work restrictions.

The Commission agrees with the Arbitrator that based on his physical abilities and educational background Petitioner has not sustained his burden of proving he is permanently and totally disabled. In addition, the Commission concurs with the Arbitrator that Petitioner's job search was not exemplary. Nevertheless, throughout the two years during which Mr. Patsavas assisted Petitioner's in his job search, he never indicated that Petitioner's job search activities were lacking in any way. In all his progress reports, Mr. Patsavas always noted that Petitioner was in compliance with the program. He seemed to change his opinion based only on the number of rounds of golf Petitioner played, which in his opinion took time away from the job search. In addition, Dr. Aribindi seemed to base his opinion that Petitioner could return to work as an ironworker without restrictions largely on his viewing of the surveillance videos. As noted above, they showed extensive gardening and golfing activities. However, as Dr. Marra noted they do not show him working overhead. While Dr. Marra testified that Petitioner may be able to work as an ironworker, he also testified that he would need restrictions. There was no evidence that Respondent ever offered Petitioner work as an ironworker within his restrictions.

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In looking at the entire record before us, the Commission concludes that the Arbitrator gave a little too much weight to Petitioner's questionable job search and the opinion of Dr. Aribindi that Petitioner was able to work as an ironworker without restrictions. While the FCE did rate Petitioner at a heavy physical demand level, Dr. Marra placed weight restrictions on him nevertheless and the Commission does not believe an employee should be forced to work in pain. Petitioner suffered a significant injury to his shoulders requiring four surgeries and which, in the opinion of the Commission, precludes him from working as an ironworker.

The Commission finds that an award of loss of 45% of the person-as-a-whole is appropriate in this claim and modifies the Decision of the Arbitrator accordingly. While the Commission modifies the permanency award, we hereby affirm and adopt all other aspects of the Order section of the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a period of 225 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the partial disability to the extent of 45% 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 $75,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: JUL 20 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-6/28/18
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0451

BLANKSHAIN, ROBERT Case# **08WC005480**
Employee/Petitioner

WALSH CONSTRUCTION
Employer/Respondent

On 7/31/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN M POPELKA
121 N CLARK ST SUITE 2100
CHICAGO, IL 60601

1682 HINSHAW & CULBERTSON LLP
PETER CARLSON
222 N LASALLE ST SUITE 300
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Blankshain
Employee/Petitioner
v.
Walsh Construction
Employer/Respondent

Case # 08 WC 5480

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **May 9, 2017 & May 10, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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?
x TPD x Maintenance x TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Other **Prospective medical, vocational expenses and credits**

FINDINGS

On January 28, 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 to his right and left shoulders are causally related to the accident.

In the year preceding the injury, Petitioner earned $78,000.00; the average weekly wage was $1,500.00.

On the date of accident, Petitioner was 47 years of age, *single* with no dependent children.

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

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

Respondent shall be given a credit of $ of $117,000.00 for TTD, $0 for TPD, $172,000.00 for maintenance, and $29,448.35 for PPD advances, as identified in Respondent's Exhibit #4, for total credit of $318,448.35.

ORDER

The Arbitrator finds the Petitioner's right and left shoulder conditions are causally related to the work accident of January 28, 2008.

Petitioner was temporary totally disabled and entitled to TTD benefits from February 5, 2008 through April 20, 2010.

Respondent shall pay Petitioner maintenance benefits from April 21, 2010 through May 9, 2011 and from May 10, 2011 through August 23, 2013 pursuant to Section 8(a) of the Act.

Petitioner is not entitled to maintenance benefits from August 24, 2013 through April 15, 2014 and November 1, 2014 through May 9, 2017 pursuant to Section 8(a) of the Act.

Petitioner failed to prove by the preponderance of the evidence that he entitled to benefits pursuant to Sections 8(f) and 8(d) of the Act.

Respondent shall pay the Petitioner the sum of $636.15 per week for a further period of 150 weeks as provided under Section 8(d)(2) of the Act because the injuries sustained caused permanent partial disability to the extent of 30% loss of use of man as a whole as provided under the Act.

Petitioner is not entitled to prospective medical expenses or vocational expenses.

Respondent shall pay Petitioner compensation that has accrued from January 28, 2008 through May 10, 2017, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

7/31/17
Date

JUL 31 2017

FINDINGS OF FACT

The parties stipulate that Respondent, Walsh Construction Company, was operating under the Illinois Workers' Compensation Act on January 28, 2008 and the Petitioner, Robert Blankshain sustained an accidental injury that arose out of and in the course of his employment by Respondent. The parties further stipulate that Respondent was given notice of the accident within the time limits stated in the Act and Petitioner's earnings during the year preceding the injury were $79,000.00 and the average weekly wage, pursuant to section 10 of the Act was $1,500.00. Respondent disputes that Petitioner's current condition of ill-being is causally connected to his injury. Petitioner claims to be entitled to TTD from 2/5/2008 through 4/20/2010, representing 115 weeks, and TPD from 4/2/2014 though10/31/2014, representing 30 2/7th weeks, and maintenance from 4/21/2010 through 4/1/2014 and from 11/1/2014 through 5/9/2017, representing 337 2/7th weeks. Respondent disputes Petitioner's claims for TTD, TPD and maintenance. Respondent claims it paid $328,448.35 in indemnity benefits and claims a credit for the amounts paid. Petitioner disputes Respondent's claim. Petitioner claims he is entitled to be reimbursed for vocational rehabilitation expenses including, in part, college tuition and interest on student loans. Petitioner further claims he is entitled to receive prospective medical care. Petitioner has filed a petition for penalties and attorney's fees pursuant to Sections 19(k), 19(l) and/or 16 of the Act.

Date of Accident

On January 28, 2008, Petitioner was employed by Respondent as an ironworker. Petitioner had been an iron worker since 2005. Petitioner testified he was pulling a reinforcement bar through a doorway when he felt a tear in his right shoulder. (Tr. 17-19). Petitioner felt pain and he could not raise his right arm above his head. After telling his supervisor, Petitioner was taken to an emergency care facility. (Tr. 19-20) On January 28, 2008, Petitioner was treated by Dr. Kirschner at Physicians Immediate Care. The history contained in the medical records indicate Petitioner was experiencing right shoulder pain after pulling a piece of rebar through an iron beam while at work. (Px 1) Petitioner's right shoulder was x-rayed and he was proscribed Ibuprofen and told to seed follow up care.

Medical Treatment

On February 4, 2008, Petitioner had an MRI of the right shoulder which showed chronic degenerative changes and possible tear of the labrum. On February 6, 2008, Petitioner was referred to Dr. Bach for an orthopedic consultation. (Px. 1) On February 12, 2008, Petitioner was examined by Dr. Kalainov of Northwestern Center for Orthopaedics. (Px 3) At this visit, Petitioner reported feeling a tearing sensation deep in his right shoulder. Petitioner, on a medical information sheet, indicated he was having right shoulder pain. Petitioner did not indicate he injured his left shoulder or he was experiencing left shoulder pain at that time. (Px. 3) Dr. Kalainov reviewed the MRI study and recommended physical therapy and strongly encouraged initial nonsurgical measures to address his shoulder pain. (Px 3) The medical records show Petitioner agreed to the treatment recommendations and was given a prescription for physical therapy.

The following day, on February 13, 2008, Petitioner was examined by Dr. Bernard Bach, of Midwest Orthopedic. At that visit, Petitioner completed a patient registration form indicating he hurt his right shoulder. The medical records do not identify any left shoulder injury or left shoulder complaints. (Px.5) Dr. Bach diagnosed Petitioner with a him with a slap tear and recommended surgery. (Tr. 24-26). On February 29, 2008, Petitioner underwent a right shoulder slap repair, biceps tenotomy and open biceps tenodesis at the Rush Surgicenter. (Px. 6)

On May 14, 2008, Petitioner returned to Dr. Bach. Petitioner said his pre-operation pain had been significantly reduced, he reported virtually no pain and that he could sleep comfortably. (Px. 5) On May 14, 2008, Petitioner returned to Dr. Bach. The medical records show Petitioner complained of left shoulder pain in essentially the same location of his pre-operation symptoms. Dr. Bach ordered an MRI of the left shoulder. Dr. Bach's notes indicate the pain could be indirectly related to heavy use. The MRI revealed some signal changes in the biceps tendon, within the bicipital groove and fluid in the intertubercular groove. On May 28, 2008, Petitioner received a steroid injection in the subacromial space of the left shoulder. Dr. Bach recommended a left shoulder arthroscopic evaluation depending upon how Petitioner responds to the injection. (Px. 5)

On June 17, 2008, Petitioner was examined by Dr. Guido Marra of Loyola Medicine pursuant to Section 10 of the Act. Petitioner provided a history of feeling a sharp pain in his right shoulder while putting together some beams. Petitioner complained of left shoulder pain and Dr. Marra asked Petitioner whether he injured his left shoulder at the time of the original accident. Petitioner said he did not recall any injury to his left shoulder. (Px 7) Dr. Marra reviewed the MRI which showed some mild heterogeneity in the proximal aspect of the biceps tendon. Dr. Marra agreed with Dr. Bach's recommendation of left shoulder arthroscopic surgery if Petitioner does not respond to the injections. Dr. Marra wrote, in his report, based upon Petitioner's history, he did not injury his left shoulder at the time of his accident. Dr. Marra believed Petitioner aggravated an underlying pre-existing bicipital tendon tear. (Px. 7) Dr. Marra testified Petitioner's preexisting left shoulder condition was aggravated when Petitioner became more dependent upon his left shoulder after the right shoulder surgery. Dr. Marra opined Petitioner's left shoulder condition was casually related to the underlying January 28, 2008 accident. (Tr. 8,9)

On July 14, 2008, Petitioner returned to Dr. Bach. Petitioner had decrease pain in his right shoulder. The pain in the anterior aspect of the right shoulder was gone. Petitioner reported receiving no relief from the steroid injection. Dr. Bach's records indicate Petitioner asked if he could play golf and Dr. Bach felt he could play golf. Dr. Bach recommended the arthroscopy evaluation. (Px. 5)

On October 3, 2008, Petitioner underwent a left shoulder arthroscopy biceps tenotomy and open biceps tenodesis. (Px. 6) On October 20, 2008, Petitioner followed up with Dr. Bach. Petitioner said his left shoulder was doing well but he was now experiencing an exacerbation of his right shoulder symptoms. Dr. Bach records indicate Petitioner was suffering of an acute exacerbation of impingement syndrome of the right shoulder secondary to overuse due to the surgery on his left shoulder. (Px. 5)

Respondent requested a Section 16 examination which was performed by Dr. Marra in January 2009. Dr. Marra recommended a diagnostic arthroscopy of the right shoulder. (Tr. 36,

37). Petitioner transferred his care and treatment to Dr. Marra, who performed a decompression of the right shoulder and hardware removal in May of 2009. (Tr. 37, 38). Thereafter, in November of 2009, Petitioner underwent a left shoulder subacromial decompression. (Tr. 39, 40).

On April 9, 2010, Petitioner underwent a functional capacity evaluation (FCE) at ATI Physical Therapy. The FCE placed Petitioner at the heavy physical demand level, Petitioner could lift bilaterally 106 pounds from desk to chair and chair to floor and 52 pounds above the shoulders. The FCE noted that Petitioner demonstrated the ability to work at the Heavy physical demand level and the D.O.T lists the job at the Heavy physical demand level. In a letter to Dr. Marra, dated April 9, 2010, Tom Werner, of ATI, wrote the patient reports he doesn't feel he can safely return to work within his existing shoulder pain and limitations and the patient may have issues with returning to work due to complaints of pain. (Px.10)

On April 20, 2010, Petitioner returned to Dr. Marra. At that time, Petitioner reported he was doing well. Dr. Marra reviewed the FCE and determined Petitioner was at MMI and he could return to work within the FCE limits. (Px. 7) Dr. Marra authored a letter returning Petitioner to work within the limits of the FCE which included the restrictions of lifting above the shoulder bilateral occasional 52 pounds, frequent 30.2 pounds, right 24 pounds, 13 pounds and left 21.8 pounds and 13.0 pounds respectively. Dr. Marra also authored a letter stating Petitioner could play golf. (Px. 7) Dr. Marra's medical records do not contain any information regarding the frequency of golf Petitioner intends to play or frequency played golf in the past. Petitioner testified, prior to his work accident, he played golf a lot and he could play 36 holes every day. (Tr. 121)

On August 17, 2010, Petitioner returned to Dr. Marra complaining of left shoulder pain for the last 2 months and his pain has been increasing. Dr. Marra gave Petitioner a steroid injection in his left shoulder. On September 28, 2010, Petitioner returned to Dr. Marra complaining of pain in his left shoulder. Dr. Marra examined Petitioner. The examination was negative for impingement sign and Hawkins test and negative speeds test and O'Brien's test. The crossover test was positive. Dr. Marra gave Petitioner a second steroid injection. On November 9, 2010, Petitioner returned to Dr. Marra complaining of left shoulder pain. Dr. Marra notes indicate he did not recommend a MR arthrogram nor any additional cortisone injections. (Px 7)

On November 22, 2010, Petitioner was examined by Dr. Raab, pursuant to Section 10 of the Act. Petitioner reported he injured his right and left shoulders when feeding a bar inside a beam. The medical records show Petitioner is an avid golfer. Dr. Raab opines Petitioner did not injury his left shoulder during the January 28, 2008 incident. Dr. Raab records say if the history is correct, it is possible that overuse of the left shoulder contributed to the necessity for treatment of the left shoulder and ultimate surgical intervention. (Px. 11)

On December 14, 2010, Petitioner returned to Dr. Marra complaining of right shoulder and left shoulder pain. Dr. Marra proscribed a MR arthrogram. Dr. Marra did not change Petitioner's work restrictions. On June 5, 2012, Petitioner returned to Dr. Marra to review the MR arthrogram. The films were negative. During that visit, Petitioner was now complaining of right shoulder pain. Dr. Marra proscribed a right shoulder MR arthrogram. Dr. Marra did not change Petitioner's work restrictions. (Px. 7)

On November 29, 2011, Petitioner was examined by Dr. Coe as the request of Petitioner's attorney. Dr. Coe opined Petitioner's bilateral shoulder symptoms was causally related to Petitioner's work accident of January 28, 2008. Mr. Coe further opined Petitioner should return to Dr. Marra to discuss additional diagnostic tests including an arthrogram of the left shoulder. (Px 12)

On August 15, 2012, Petitioner returned to Dr. Marra to review the MR arthrogram. The right shoulder MR arthrogram films was negative. At that time, Dr. Marra performed an examination. Petitioner's external rotation was 80, internal rotation was L3. Petitioner had a negative Hawkins' Test, negative crossover test, negative Speed's and Obrien's Test and was negative for signs of impingement. Petitioner did not have any AC joint tenderness. Dr. Marra did not recommend any additional but proscribed Celebrex to use on a p.r.n. basis. (Px. 7)

On June 21, 2016, Petitioner returned to Dr. Marra with a CD that Petitioner states was from his lawyer showing him mulching lawns. The video is an hour and a half long. Dr. Marra's records show he told Petitioner it was inappropriate for an office visit and if his lawyer wants him to review the video, it should be edited down to 5 minutes. (Px. 8) Petitioner testified he condensed the video down to 5 minutes and brought it back to Dr. Marra. (Tr. 76) Dr. Marra testified he only reviewed the 5-minute video Petitioner had edited and he did not reviewed the full video. (Px. 10, pgs. 37, 38) The Arbitrator reviewed the 5-minute video provided to Dr. Marra, and compared the 5-minute video to the actual surveillance videos. The Arbitrator found the 5-minute video failed to contain several significant physical activities depicted on the surveillance videos.

Work History prior to 2008

Petitioner worked as an ironworker from 2005 through 2008. From 2002 until 2005 Petitioner testified he was unemployed and did nothing during this period. (Tr. 113). From 1990 through 2000, Petitioner was a stockbroker earing $250,000 a year. Petitioner was senior vice president of investments for Wachovia Financial Services in 2000. Petitioner had a Series 7 license, for trading equities, and a Series 63 licenses, for selling mutual funds. (Tr. 106-109). Petitioner does not believe the licenses are still valid and, since his work accident, Petitioner has not contemplated retaking the tests to reinstate the licenses. (Tr. 109). Prior to being a stockbroker, Petitioner worked as a welder but he is not currently certified as a welder. (Tr. 114)

Post-Accident Activities

In 2008, Petitioner enrolled at DePaul University to obtain a bachelor's degree in finance. At the time Petitioner enrolled in DePaul, he was still undergoing medical treatment and was not at MMI. (Tr. 45-46). Dr. Marra found Petitioner to be at MMI on April 20, 1010. Petitioner graduated in June of 2011 with a 3.99 GPA out of 4.0. (Tr. 147). Petitioner earned several honors including Golden Key Honor Society, Phi Kappa Pho Honor Society and DePaul Honor Society. (Px 17) Petitioner testified he went back to college because he wanted to diversify is occupation and to improve the possibility of getting another job and start another life. (Tr. 145, 146) Petitioner acknowledged that no one associated with his worker's compensation claim discussed with him going back to college. (Tr. 166)

From February 2010 through May of 2011, Petitioner testified he conducted a self-directed job search. (Tr. 48-49). Petitioner would perform his job search between 3-4 in the morning until noon every day. (Tr. 58). Petitioner said he conducted the job search early in the morning because the house was quiet and he could get his search out of the way so he could have the rest of his day. (Tr. 56)

Petitioner testified he focused his self-directed job search toward executive positions within a medium salary range between $80,000 to $100,000 per year range. (Tr. 155, 156). Petitioner explained he did not seek jobs in the $40,000 to $60,000 range because those jobs involve physical labor and, he doesn't believe, he can do physical labor anymore. (Tr. 155,156) Petitioner testified he applied for medium level executive salary positons because he wants to do executive work and he was not going to do anything physical. (Tr. 156) Petitioner testified his self-directed job search did not include jobs considered heavy physical demand and he only applied for jobs based upon his educational background. (Tr. 157, 158) Petitioner acknowledged he could work within the restrictions of the FCE with pain and he could perform a medium physical demand job. (Tr. 160, 167) Petitioner did not receive any job offers.

Petitioner testified before his work accident he played a great deal of golf and he could pay 36 holes a golf every day without pain. (Tr. 121) After the accident, Petitioner could only play golf every other day and he could only play 18 holes. Before the accident, Petitioner's golf handicap was 2 and after the accidents his handicap was between 12 and 14. (Tr. 126). Petitioner said it takes him between 3-4 hours to play a round of golf. Petitioner testified playing golf causes him to experience pain. (Tr. 122,123). Petitioner said he may not start out in pain but by the end of the round his shoulders are sore and that is why he only plays golf every other day and only 18 holes. (Tr. 124,125)

Petitioner admitted golfing 21 rounds of golf from July 26, 2013 through October 9, 2013. (Tr. 214, 215). Petitioner's golf scores were published on the website for the Chicago District Golf Association. (Rx. 1, Ex. 7). Petitioner's golf scores from July 26, 2013 through October 9, 2013 area as follows:

Date	Course	Score
7/26/2013	Meadows GC: Blue	80
7/28/2013	Harborside Interl. Starboard: Championship/blue	90
7/30/2013	Balmoral Woods: White	85
8/8/2013	Course at Aberdeen, IN	92
8/10/2013	Seven Bridges: Gold	93
8/13/2013	Meadows Golf Club of Blue Island	77
8/15/2013	Harborside Interl. Center	105
8/18/2013	Lake Michigan Hills, MI	95
8/20/2013	Meadows GC: White	79
8/21/2013	Cog Hill: #1: Black	80
8/24/2013	The Brassie GC, IN	92
8/26/2013	Meadows GC: Blue Island	86

8/29/2013	Meadows GC: Blue Island	84
9/4/2013	Merit Club	97
9/9/2013	Fresh Meadow GC	87
9/10/2013	Sanctuary GC	85
9/12/2013	The Brassie GC	85
9/16/2013	The course at Aberdeen, IN	91
9/23/2013	Seven Bridges GC: Green	88
9/25/2013	Maple Meadows	87
10/9/2013	Seven Bridges	93

Post-Accident Employment:

On April 14, 2014, Petitioner accepted a position for employment at George A. Kennedy & Associates, Ltd., as an assistant project coordinator earning $2,333.33 per month. (Px. 17) Petitioner testified his girlfriend's father owned the company. (Tr. 75) Petitioner testified he only worked for approximately 6 months because work dried up. (Tr. 74) Documents from George Kennedy and Associates indicates the job was for a temporary position with a scheduled termination date of October 31, 2014. (Px 17) Petitioner's first date of employment was April 15, 2014. Petitioner testified he was overqualified for the positon but the job gave him something to do and occupied some of his time. (Tr. 155) Mr. Patsavas testified Petitioner's job at George Kennedy required a high school degree, had no opportunity for advancement and was well below Petitioner's earning capacity. (Rx. 1, pgs. 66-68, 71-72, 77). Mr. Grzesik opined the amount Petitioner earned at George Kennedy was consistent with what the labor market provided for an entry-level wage for the type of job (assistant project manager). (Px. 16. pgs. 51-54).

David Patsavas Deposition

In May 2011, a vocational rehabilitation consultant, David Patsavas, was retained to assist Petitioner's job search efforts. (Tr. 48, 49). Mr. Patsavas believed Petitioner could benefit from short-term vocational rehabilitation services to assist Petitioner returning to gainful employment including his job seeking skills and job readiness. (Rx. 1, pg. 21). Mr. Patsavas said Petitioner qualified for 90% of the job market because of two factors: Petitioner's heavy category of physical demand and Petitioner's transferable skills and prior work history. (Rx.1, pg. 39) Mr. Patsavas testified, pursuant to the Dictionary of Occupational Titles, an iron worker is considered to be in the heavy category of physical demand level. (Rx. 1, pg. 13)

Mr. Patsavas recommend Petitioner alter his job search to include jobs earning between $50,000 to $60,000.00. (Rx 1, pg. 44) Mr. Patsavas testified Petitioner's asking price was too high to what Petitioner was bringing to the table. Mr. Patsavas, believed Petitioner's 10-year work history as a stockbroker was relevant to Petitioner's ability to find work. (Rx. 1, p. 33). Petitioner possessed transferable skills in the financial industry, including security, banking, and handling money. (Rx. 1, pgs. 29-32). Petitioner also had experience working with his hands and metals, and had performed supervisory foreman work. (Rx. 1, pg. 30) Mr. Patsavas worked with Petitioner for approximately two years. Mr. Patsavas testified Petitioner was getting interview but he was

not receiving any job offers. (Rx. 1 pg. 44) Mr. Patsavas testified he did not have any evidence that Petitioner was sabotaging or performing poorly during the interviews. (Rx. 1, pg. 127)

Mr. Patsavas's services ended on August 23, 2013 after concluding he could not offer Petitioner anything more in job search vocational services. (Rx. 1, pgs. 78,79). Mr. Patsavas testified after two years, Petitioner was using the same resources and identifying the same job leads as his service provided so there was nothing else that could be done for Petitioner. (Rx. 1, pg. 191) Mr. Patsavas notified Petitioner vocational rehabilitation services were ending because nothing else could be done for him pursuant to the *National Tea* test. (Rx. 1, pgs. 78,79). Vocational services terminated on August 23, 2013.

Mr. Patsavas testified based upon the information he had at the time, Petitioner's job search and logs were diligent. (Rx. 1, pg 96) Mr. Patsavas said the criteria for diligence was making 20-30 employer contacts a week. (Rx. 1, pg. 95) Mr. Patsavas testified Petitioner told him he only golfed once in a while. (Rx. 1., pg. 115) Mr. Patsavas testified, based upon Petitioner's golf scores, he no longer believed Petitioner was putting forth a full-time effort to secure employment. (Rx. 1., pgs. 136,137) Mr. Patsavas testified the rounds of golf Petitioner was playing did not factor into his decision to recommend stopping vocational placement services. (Rx. 1, pg. 194)

Initially, Mr. Patsavas had no explanation as to why Petitioner had not secured employment with his earning capabilities as he should have found suitable employment. (Rx. 1. Pgs. 207-210). Mr. Patsavas testified the vocational process should take 6 months. (Rx. 1, pg. 210) Mr. Patsavas testified he did not expect it to take long to place Petitioner based upon the factors of completing college, experience at Wachovia and experience in the construction industry. (Rx. 1, pg. 210) Mr. Patsavas testified Petitioner never mentioned golfing or the 20 rounds of golf he played between 6/26/13 and 9/26/13 (Rx. 1, pgs. 54-56). Mr. Patsavas testified the amount of golf helped explain why Petitioner's job search was less than diligent. (Rx. 1, pgs. 211-214, 69-70).

Mr. Patsavas performed a labor market Research Report on November 14, 2014. Based upon the Petitioner's transferable skills, potential areas of employment, heavy category of physical activity and college degree, Mr. Patsavas found Petitioner qualified for 90% of all jobs. (Rx. 1 Pgs. 64, 65) Mr. Patsavas opined Petitioner's median hourly rate of pay for jobs he was qualified to perform was between $26.00 and $42.00 per hour. (Rx. 1, pg. 65). Mr. Patsavas opined Petitioner's earing capacity was between 50,000.00 and $80,000.00 per year. (Px. 1, pg. 71)

Mr. Patsavas testified Petitioner had almost completed his degree when he first met with Petitioner. Mr. Patsavas testified Petitioner's degree did not increase the likelihood of finding a job but may increase the potential income level. (Rx. 1, pg. 133)

Mr. Patsavas testified he would not have recommended Petitioner working at George Kennedy & Associates earning $28,000.00 per year because the rate of pay was artificially low compared to Petitioner's earning capacity. (Rx. 1, pg. 220) Mr. Patsavas did not feel the positon was appropriate. Mr. Patsavas testified he did not think the job was appropriate given Petitioner's degree and everything else. (Rx. 1, pgs. 222–230)

Thomas Grzesik Deposition

Petitioner retained Thomas Grzesik as a vocational expert. (Px. 16, pgs. 9-11). Mr. Grzesik had one meeting with Petitioner which occurred on October 16, 2014. Mr. Grzesik did not conduct a labor market survey. (Px 16, pg. 54) Mr. Grzesik did not know what grades Petitioner earned while attending college. (Px 16, pg 98) Mr. Grzesik was not aware prior to his deposition Petitioner was no longer working at George Kennedy & Associates. (Px 16, pg 48) Mr. Grzesik testified Petitioner worked as an iron worker for 8 years. (Px 16, pg 31) Mr. Grzesik acknowledged he spent 15 minutes reviewing Petitioner's self-directed job search from November 1, 2011 through July 31, 2015 and his search consisted of flipped through each page. (Px. 16, pg. 64, 65) Mr. Grzesik testified Petitioner said he only, occasionally, plays golf since his injury. (Px. 16, pg. 20) Mr. Grzesik testified Petitioner said he could only drive for 30 minutes before experiencing pain and he could only drive for a total of one hour. (Rx. 16, pgs 86,87) Mr. Grzesik also indicated Petitioner said he experiences significant bilateral shoulder pain after walking 2 miles and after working on a keyboard for a few hours. (Px 16, pg 75, 76)

Mr. Grzesik testified he disagrees with opinions of Dr. Marra and the FCE regarding Petitioner's physical components of iron working and that Petitoner is capable for performing heavy duty work. (Px 16, pgs. 13, 80) Mr. Grzesik opined Petitioner was not capable of performing his prior occupation as a journey man iron worker. (Px 16, pg 41) Mr. Grzesik testified Petitioner should be seeking light-level work based on Petitioner's pain complaints. (Px. 16, pgs. 82-85). Mr. Grzesik believes Petitioner should looking for occupations related to what he did at George Kennedy and Petitioner's records show he was only pursuing light to sedentary employment over the past 2 years. (Px 16, pg. 81)

Mr. Grzesik disagreed with Mr. Patsavas regarding Petitioner being employable at a $50,000.00 salary level. (Px 16, pg 26) Mr. Grzesik disagreed with Mr. Patsavas's analysis because Mr. Patsavas included finance jobs requiring 2-5 years of experience and the experience sought was 2-5 years of recent experience and not 2-5 years of experience over the past 15 years. Mr. Grzesik did not believe Petitioner had the relevant experience to apply for the jobs he was applying while working with Mr. Patsavas. Mr. Grzesik testified remained unemployed in the area of finance because of his lack of experience. (Px 16, pg 25-27) Mr. Grzesik further testified Petitioner's lack of recent experience in the financial market, not having a higher degree, either a MBA or charted financial advisor certificate (CFA), and Petitioner's age were factor working against Petitioner. (Px 16, pg 44)

Mr. Grzesik testified he did not believe obtaining a master's degree would have been appropriate because of Petitioner's age and new hybrid MBAs, in finance, which now include charted financial advisor training (CFA). (Px 16, pg. 24) Mr. Grzesik believed obtaining the bachelor's in finance could have been a reasonable first step had Petitioner continued in the process and procured his CFA back in 2011. (Px 16, pg. 27) Mr. Grzesik testified the degree Petitioner earned does not and has not increased Petitioner's earning capacity. (Px 16, pg. 57)

Mr. Grzesik testified Petitioner's job search did not include jobs involve pushing or pulling on a repetitive basis. (Px 16, pg 84) Mr. Grzesik further testified Petitioner's job search did not

include driving. (Px 16, pg 88) Mr. Grzesik recommends vocational services going forward because he believes Petitioner could find a job. (Px 16, pgs. 117,118)

Testimony of Dr. Marra

Dr. Marra testified Petitioner's condition of ill-being with respect to the bilateral shoulders injuries were causally related to Petitioner's work accident of January 28, 2008 and the medical care, including the bilateral shoulder surgeries and injections, were reasonable and necessary to cure or relieve Petitioner from the effects of his condition caused by the January 28, 2008 accident. (Px. 10, pg. 28)

Dr. Marra testified after reviewing the MR arthrogram, on August 15, 2012, he did not feel there was anything further to do for Petitioner other than taking anti-inflammatory medications and issuing work restrictions. (Px. 20, pg. 22) Dr. Marra testified the anti-inflammatory medicines, Celebrex, was proscribed to deal with Petitioner's complaints of occasional pain and if Petitioner did not complain of pain than he would not give him Celebrex. (Px. 20, pg 43) Dr. Marra acknowledged there were no findings from the surgery require the need for Celebrex and he proscribes Celebrex to Petitioner when Petitioner says his shoulders hurt. (Px. 20, pg. 43)

Dr. Marra testified Petitioner could return to work as an ironworker if Petitioner would abide by his restrictions. (Px. 10, 23) Dr. Marra testified he did not believe Petitioner could go back to iron working unless some form of accommodations were made. (Px. 10, pg. 30) Dr. Marra testified Petitioner does not have strength in an overhead position so if Petitioner reached out into space or in an overhead position, he would have limitations in how much he'd be able to lift. (Px. 20, pg. 30) However, Dr. Marra testified if Petitioner would want to return to ironworking, he would tell Petitioner to give it a shot. (Px. 20, pgs. 59,60)

Dr. Marra testified he did not review Dr. Aribindi's report of July 11, 2016 prior to his evidence deposition. (Px. 20, pg. 34) After reviewing Dr. Aribindi's report, Dr. Marra was asked to identify any differences between his last examination of Petitioner and Dr. Aribindi's examination. Dr. Marra acknowledged he could only find slight discrepancies between the finding of the two examinations. Dr. Aribindi found no evidence of impingement in either shoulder and Dr. Aribindi found normal strength in manual muscle testing. Dr. Marra testified he found evidence of impingement and Petitioner's strength was slightly less than normal. (Px. 20, pg 37)

Dr. Marra testified he was aware Petitioner played golf but he did not know any specifics regarding how often he's playing. (Rx. 20, pg 39) Dr. Marra testified he only reviewed the 5 minute video Petitioner edited and he had not reviewed the unedited videos. (Rx. 20, pg. 25) Dr. Marra did not recall seeing Petitioner carrying bags of mulch in the video. (Tr. 20, pg. 42)

IME

Petitioner was examined by Respondent IME physician Dr. Ram Aribindi on July 11, 2016. (Rx. 2). Petitioner reported he injured his right shoulder on January 28, 2008 while pulling an iron bar through beams. Petitioner noted a tearing sensation in his right shoulder and indicates he has

some pain about the right and left shoulders with overhead activities. Petitioner reported that he was doing well. Petitioner reported he regularly plays golf once or twice a week and Petitioner denied any experiencing any clicking or popping of the shoulders.

Dr. Aribindi performed an examination of the right shoulder and noted full active forward elevation, abduction, external rotation as well as adduction/ internal rotation of the shoulders. Dr. Aribindi found Petitioner's strength was 5 over 5 in all planes and no signs of impingement. The O'Brien's, Speed's and Load Shit tests were all negative. Dr. Aribindi found no apprehension with abduction extended rotation of the shoulders or with flexion, adduction, internal rotation of the shoulder. (Px. 3)

The examination of the left shoulder showed no tenderness over the clavicle or the ac joint, full active forward elevation, abduction, external rotation as well as adduction/internal rotation. Range of motion was symmetric with the right, and strength was 5 over 5 in all planes. Dr. Aribindi found no signs of impingement and the O'Brien's, Speed's and load shift tests were negative. No apprehension with abduction extended rotation of the shoulder with flexion, adduction, internal rotation of the shoulder.

Dr. Aribindi indicated he reviewed all the surveillance videos and reviewed Petitioner's medical records. Dr. Aribindi opined based on the history, exam and review of the imaging studies and surveillance, there are not physical restrictions to performing his regular work activities at the heavy-duty level of an iron worker. Petitioner is at maximum medical improvement and no further diagnostic workup or treatment is necessary. Dr. Aribindi indicated the video surveillance showing Petitioner lifting and carrying multiple bags of dirt and landscaping/gardening is consistent with his findings that Petitioner is capable of performing work at the heavy-duty level as an iron worker. (Px. 3)

Trial Testimony – Petitioner

Petitioner testified he worked for Respondent 2-3 years as a structural ironworker. (Tr. 12) Prior to becoming an ironworker, Petitioner worked as a stockbroker from 1990 to 2000 earning $250,000.00 per year. Petitioner had a Series 7 license to sell securities and a Series 63 license to sell mutual funds. (Tr. 98, 108) From 2000 until 2005 Petitioner was unemployed. (Tr. 113) During the 1980's Petitioner worked as an ironworker and a welder but he was not certified as a welder. (Tr. 95,114)

Petitioner testified he injured both shoulders on the date of the accident and he experienced immediate discomfort in his left shoulder and severe pain in his right shoulder. (Tr. 118-120). Petitioner testified Dr. Marra released him to return to work within the parameters of the FCE, which placed him at the heavy level of activity. (Tr. 41-42). Petitioner agreed the FCE indicates he can work at the heavy physical demand level. (Tr. 152-154). Petitioner agrees he could work at that level but not without pain. (Tr. 152) Petitioner acknowledges he could work at a medium physical demand job if he is not lifting 50 pounds overhead repeatedly. (Tr. 160)

Petitioner testified he enrolled in college at the University of DePaul in 2008. (Tr. 46) At the time Petitioner enrolled in college he was still undergoing medical treatment. (Tr. 46)

Petitioner testified he enrolled in college because he wanted to diversify his occupation and to improve his possibilities of getting another job and starting another life. (Tr. 146, 167) Petitioner testified he enrolled in college despite not knowing whether he would be able to return to ironworking. (Tr. 143-146). He acknowledged he was not directed by Respondent to return to college. (Tr. 166-167). Petitioner graduated from DePaul University with a 3.99 G.P.A. out of 4.0 in June of 2011 with a degree in finance. (Tr. 46, 146, 167) Petitioner testified he started working with the vocational consultant, David Patsavas, on May 10, 2011. (Tr. 48,49)

Petitioner testified he started his self-directed job search on February 1, 2010. Petitioner tried to make 5 to 6 contacts a day for 7 days a week. (Tr. 44,55) Petitioner testified he performed his job search from 3 or 4 a.m. until noon each day because the house is quiet and he could have the rest of his day. (Tr. 55, 58) Petitioner testified he focused his self-directed job search only at those jobs earning between $80,000.00 to $100,000.00 per year. (Tr. 61) Petitioner explained he targeted medium salaries for executives and he didn't want to go down to the $40,000.00 to $60,000.00 salary range because he can't do physical labor anymore. Petitioner further testified he was not going to do anything physical, he could do executive work. (Tr. 155,156)

Petitioner testified his job search did not include any heavy physical demand jobs. (Tr. 157) Petitioner further testified he restricted his job search toward his educational degree. (Tr. 158) Petitioner said it was his educational experience that made his job search not his physical capabilities. (Tr. 159) Petitioner acknowledged while working with Mr. Patsava, Petitioner started to seek employment to include positions earning between $50,000.00 to $60,000.00 but after the vocational services were terminated Petitioner only apply for positons earning between $80,000.00 and $100,000.00. (Tr. 61,71,179) Petitioner testified he did not try return to work as a stockbroker. (Tr. 249) Petitioner did not seek to reinstate his Series 7 or Series 63 licenses. (Tr. 107, 109) Petitioner did not attempt to return to work as an ironworker and did not ask the union for retraining or seek work as a welder. (Tr. 149)

Petitioner testified before his accident he could play 36 holes of golf a day every day without pain and since the accident he only plays 18 holes of golf every other day. (Tr. 121) Petitioner acknowledges he experiences pain while playing golf and the pain increases while playing golf. (Tr. 122,123) Petitioner testified before the accident, his handicap was 2 and he was shooting in the 70s. and now his handicap is 12-14 and he is shooting in the 80s. (Tr. 125-127). Petitioner acknowledged playing golf 21 times during the period between July 26 and October 9, 2013. (Tr. 214-215). Petitioner said Dr. Bach gave him the impression he could play golf. (Tr. 29,30) Petitioner acknowledges he told Dr. Aribindi he played golf 1-2 times a week. (Tr. 172)

Petitioner testified he started working for George Kennedy & Associates on April 1, 2014 and worked until October 31, 2014. (Tr. 72, 73) Petitioner testified the reason why he stopped working for George Kennedy & Associates is that work dried up. Petitioner said his girlfriend's father owns the company. (Tr. 75) Petitioner testified he was overqualified for the job at George Kennedy & Associates but the job gave him something to do to occupy is time. (Tr. 155) After leaving George Kennedy & Associates, Petitioner resumed his self-directed job search. (Tr. 75)

Petitioner testified he condensed the surveillance video down to 5-minutes and gave the edited video to Dr. Marra. (Tr. 76) Petitioner also testified he disagreed with some of the information in Mr. Greszick's report dated February 5, 2015. (Tr. 185) Petitioner testified he has pain every day but the amount of pain he has changes. (Tr. 202) Petitioner said most of the time his pain level is 6-8 out of 10. (Tr. 245-248).

Petitioner testified within the last 2 months he applied for 2 jobs at Walsh Construction but he has not heard back. (Tr. 205-206). One of the positions, assistant project manager, has a salary range between $75,000.00 and $100,000.00 per year. (Tr. 205, 206) Petitioner testified he worked as foreman ironworker for other companies but not for Walsh and he has some knowledge of plans and blueprints. (Tr. 207-208).

Petitioner testified he disagreed with some of the information in Mr. Greszick's report dated February 5, 2015. (Tr. 185) Petitioner testified he doesn't believe he told Mr. Greszick he could only stand for two hours. (*Id.* at p. 189).

Trial Testimony – James Gabriel O'Kane

Mr. O'Kane testified he is an ironworker superintendent with Walsh and a member of the Ironworkers Union Local Number 1 and he has been a foreman's superintendent for over 30 years and he was at the 14th and Michigan site, in 2008, where Petitioner was injured. (Tr. 265-270) Mr. O'Kane testified about the physical demands of ironworking. Mr. O'Kane testified ironworkers do not need to lift things over their head they just need to lift things to your shoulder. (Tr. 270) . Mr. O'Kane further testified as follows:

Mr. O'Kane: On the core walls, you are not really lifting a lot. Probably less than a hundred pounds because you are not carrying any rebar. You are getting it passed to you to install. (Tr. 273).Mr. O'Kane further testified that two people work in partners to lift the 100 pounds together, or 50 pounds each. (Tr. 273). The general foreman and superintendent do not have to do lifting. (Tr. 274). Welders do not lift much. They get their leads out from the machine. They bring their welding rods. There might be an occasional plate they have to bring out to weld onto something. Mr. O'Kane also testified that in his experience welding is a medium job of 50 pounds. (Tr. 276).

Surveillance

Surveillance was conducted and the reports and videos were admitted as Respondent Ex. 2. Surveillance tapes of April 13, 2017 show Petitioner assisting landscapers unloading trees from a truck and moving trees, using a large handcart and assisting the planting the trees. Petitioner is observed using a large hand cart exerting force with his arms extended at and above his shoulders. (Rx 2) Surveillance tapes of June 2, 2016 show Petitioner unloading bags of mulch from a dark color minivan or SUV and performing gardening work which included lifting, carrying and dumping large bags for mulch. Petitioner is scene carrying two large bags of much at one time. Petitioner is observed breaking branches, by holding the branches in front of him at chest or shoulder high and squeezing his hands together to break the branches, and Petitioner is also

observed stuffing the broken branches into a blue garbage can. In other surveillance videos Petitioner is observed loading and unloading golf bags into and out of his trunk and playing golf. (Rx 2)

The Arbitrator finds the testimony of Petitioner not to be credible.

CONCLUSIONS OF LAW

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

The employee bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 867 (2010). Among the elements that the employee must establish is that his condition of ill-being is causally connected to his employment. *Elgin Board of Education U-46 v. Workers' Compensation Comm'n*, 409 Ill. App. 3d 943, 948 (2011). Thus, if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. The Industrial Comm'n, 207 Ill.2d 193, 797 N.E. 2d 665, 278 Ill. Dec. 70 (2003)*. "[*A*] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd dist. 2000). Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976). It is well established that an accident need not be the sole or primary cause as long as employment is a cause of a claimants' condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 205 (2003). An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where the employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36 (1982).

WITH RESPECT TO ISSUE (F) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CASUALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes Petitioner has proven by a preponderance of the evidence Petitioner's right and left shoulder conditions are causally related to the work accident of January 28, 2008. Petitioner testified he injured both his right and left shoulders on January 28, 2008. However, the medical records and various histories Petitioner provided to the medical providers show that Petitioner did not injury his left shoulder on January 28, 2008. Dr. Marra and Dr. Bach believe Petitioner later injured his left shoulder by aggravating a preexisting condition caused by the overuse due to Petitioner's right shoulder surgery. Dr. Marra said based upon the Petitioner's history, Petitioner did not injure his left shoulder at the time of his accident, he aggravated an underlying pre-existing bicipital tendon tear. (Px. 7) The Arbitrator finds this factual discrepancy concerning and reflective of Petitioner's credibility. However, given the

totality of the Record the Arbitrator finds that the work accident of January 28, 2008 caused Petitioner to sustain injuries to both his right and left shoulders.

WITH RESPECT TO ISSUE (K) IS PETITIONER ENTITLED TO RECEIVE TTD BENEFITS, MAINTENANCE AND TPD BENEFITS, THE ARBITRATOR FINDS AS FOLLOWS:

1. **Petitioner claims he was temporarily totally disabled from February 5, 2008 through April 20, 2010 representing 115 weeks.**

Petitioner was off work from as of February 5, 2008 and Dr. Marra found Petitioner reached maximum medical improvement or MMI on April 20, 2010. On that date, Dr. Marra reviewed the FCE and determined Petitioner was at MMI and found Petitioner could return to work heavy duty work pursuant to the limits in the FCE. (Px. 7) Dr. Marra authored a letter returning Petitioner to work within the limits of the FCE which included above shoulder lifting bilateral occasional 52 pounds, frequent 30.2 pounds, right 24 pounds, 13 pounds and left 21.8 pounds and 13.0 pounds respectively. Respondent IME physician Dr. Ram Aribindi examined Petitioner on July 11, 2016 and found Petitioner to be at MMI but Dr. Aribindi did not provide an opinion regarding Dr. Marra's determination of MMI on April 20, 2010. Once a claimant has reached MMI, an injury has become permanent and he is no longer eligible for TTD benefits. *Nascote Industries v. Industrial Comm'n*, 353 Ill. App. 3d. 1067, 1072 (5th Dist. 2004) (*citing Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill.2d 107, 118 (1990)).

The Arbitrator finds Petitioner reached MMI on April 20, 2010 pursuant to Dr. Marra's finds of April 20, 2010. The Arbitrator further finds Petitioner was temporary totally disabled from February 5, 2008 through April 20, 2010, representing 115 weeks.

2. **Petitioner claims he was entitled to maintenance benefits from April 21, 2010 through April 1, 2014 and from November 1, 2014 through May 9, 2017.**

Respondent started paying PPD benefits on August 13, 2013 and continued to pay PPD benefits through March 10, 2014. Respondent made two additional PPD advances totaling $11,000.00 ($6,000.00 paid on 6/15/2016 and $5,000.00 paid on 10/18/2016). (Px. 4) During this time, Petitioner was at MMI.

a. Maintenance benefits from April 21, 2010 through May 9, 2011.

Petitioner had reached MMI on April 20, 2010. On May 10, 2011, Respondent initiated vocational rehabilitation and retained the services of David Patsavas of Independent Rehabilitation Services, Inc. (Rx. 1) Petitioner's first meeting with Mr. Patsavas occurred on May 10, 2011. Mr. Patsavas testified vocational rehabilitation services were terminated after two years because Petitioner was using the same resources and identifying the same job leads and, therefore, there was nothing more he could do for Petitioner. (Rx. 1, pg. 191) The Arbitrator finds the Respondent properly terminated vocational rehabilitation services on August 23, 2013 after Mr. Patsavas notified Petitioner his services were ending pursuant to the *National Tea* test. (Rx. 1, pgs. 78,79).

For the period Petitioner reached MMI, April 20, 2010, prior to Respondent initiating vocational rehabilitation services, May 10, 2011, Respondent paid Petitioner benefits at the TTD rate. (Rx. 4) Petitioner testified he started a self-directed job search on February 1, 2010. (Tr. 44) Mr. Patsavas reviewed Petitioner's job search and did not find a lack of diligent self-directed job search. The only problem Mr. Patsavas found with Petitioner's self-directed job search involved Petitioner was eliminating job opportunities by limiting his job search to those jobs earing salaries between $80,000.00 and $100,000.00 a year. (Rx. 1, pg. 96) Mr. Patsavas requested Petitioner to broaden his job search to include jobs with annual salaries between $50,000 to $60,000.00, and Petitioner complied. (Rx. 1, pg. 44) Respondent did not present evidence that Petitioner's self-directed job search, from April 21, 2010 through May 9, 2011, was unsatisfactory or not diligent. Had Respondent objected to Petitioner's self-directed job search, Respondent could have corrected his job search to comply with Respondent's objections. That did not occur. Therefore, the Arbitrator finds Petitioner's self-directed job search from April 21, 2010 through May 9, 2011 was diligent and part of a vocational rehabilitation plan which entitle Petitioner to maintenance benefits as pursuant to *Archer Daniels Midland Co. v. Industrial Commission*, 138 Ill.2d 107, 561 N.E.2d 623, 149 Ill.Dec. 253 (1990). Therefore, Petitioner is entitled to maintenance benefits from April 21, 2010 through May 9, 2011.

b. For the period of May 10, 2011 through August 23, 2013

For the period Respondent was providing vocational rehabilitation services, May 10, 2010 thought August 23, 2013, the Arbitrator finds Petitioner is entitled to maintenance benefits pursuant to *Archer Daniels Midland Co. v. Industrial Commission*, 138 Ill.2d 107, 561 N.E.2d 623, 149 Ill.Dec. 253 (1990). Maintenance is a component of vocational rehabilitation. The Arbitrator finds Respondent acknowledged Petitioner was entitled to vocational rehabilitation and maintenance when Respondent elected to provide vocational rehabilitation services to Petitioner. Therefore, the Arbitrator finds Petitioner is entitled to maintenance during the period Respondent provided vocational rehabilitation services from May 10, 2011 through August 23, 2013.

c. For the period of August 24, 2013 through April 15, 2014

Petitioner is seeking maintenance benefits from after the termination of vocational services, 8/24/2013, though the date Petitioner started working for George A. Kennedy & Associates, Ltd., April 15, 2015. Based upon the reasoning below, the Arbitrator finds that the Petitioner failed to prove by the preponderance of the evidence he is entitled to receive maintenance benefits from August 24, 2013 through April 15, 2014.

Petitioner testified that after vocational rehabilitation services terminated he resumed his self-directed job search and redirected job search toward only executive jobs earning $80,000.00 to $100,000.00. (Tr. 71) Mr. Patsavas advised Petitioner to lower his salary expectations to ~~$50,000.00 to $60,000.00 salary range to increase the number of possible job opportunities.~~ Mr. Patsavas testified Petitioner's asking price of $80,000.00 to $100,000.00 is too high for what Petitioner was brining to the table and that is why it needed to lowered. (Rx. 1, pg. 178) Mr. Grzesik, a vocational counselor, retained by Petitioner, testified Petitioner's salaries expectations should have been lower than $50,000.00 because of Petitioner's lack of experience, lack of higher

credentials and age. (Px 16, pg. 27) Regarding experience, Mr. Grzesik explained companies are looking for 2-5 years of current experience, not 2-5 years of experience over 15 years. Mr.Grzesik testified Petitioner did not have relevant experience to search for the types of jobs Petitioner was seeking. (Px. 16, pg. 26) The Arbitrator finds Petitioner's decision to disregard the recommendation of Mr. Patsavas and only apply for jobs earning between $80,000.00 and $100,000.00 was an inappropriate limitation on his self-directed job search, rendering it ineffective.

Petitioner testified he only wanted executive position earning a certain amount because he did not want to do anything physical anymore. (Tr. 156) Petitioner placed additional limitations upon his job search rendering the job search ineffective. Petitioner acknowledged the FCE released him back to work at heavy duty level (Tr. 152) yet Petitioner testified he was not looking for jobs with heavy physical demands. (Tr. 157) Petitioner testified he directed his job search only toward his educational background. (Tr. 158) During cross examination, Petitioner was asked whether he was looking for jobs that involved physical demands of medium or heavy level and Petitioner responded he was looking for jobs within his educational experience. (Tr. 158, 159) Contrary to opinions of Dr. Marra and the FCE, Petitioner testified he can't do physical labor anymore and he is not going to do anything physical anymore. (Tr. 156, 157) Petitioner testified he did not include jobs with a salary range of $40,00.00 to $60,000.00 in his job search because Petitioner did not want to do physical labor. (Tr. 156) Based upon the above, the Arbitrator finds Petitioner's job search was rendered ineffective by his failing to include categories of jobs within Petitioner's restrictions which Petitioner, unilaterally and without sufficient justification, removed from his self-directed job search. The Arbitrator finds Petitioner's conduct made his self-directed job search ineffective and, therefore, the self-directed job search should be given very little weight and the self-directed job search should be found not to be diligent.

From June 26, 2013 through October 9, 2013, Petitioner acknowledged playing 21 rounds of golf and that he plays golf every other day. (Tr. 213, 121) Petitioner's golf scores were published on the website for the Chicago District Golf Association (Rx. 1, Ex. 7) which reviled Petitioner played multiple rounds of golf a week. Petitioner testified it would take him 3-4 hours to golf a round of golf. (Tr. 128) Several of the golf courses listed on the Chicago District Golf Association's website were in Indiana. (Rx. 1, Ex. 7) Playing a round of golf may take Petitioner 3-4 hours to play, however, Petitioner was not available for much longer than 3-4 hours a day, every other day, when one accounts for traveling time.

After reviewing the Petitioner's golf scores, Mr. Patsava opined Petitioner was not putting forth a full effort into his job search. (Rx. 1, pg. 137) The Arbitrator finds the frequency of golf Petitioner further eroded the adequacy of his self-directed job search. The Arbitrator hereby finds the Petitioner's self-directed job search after the termination of vocational rehabilitation services, was not diligent based upon the frequency of golf Petitioner played and the various limitations Petitioner placed on his job search. Good faith effort and whether a job search is diligent does not solely depend upon the number of resumes sent during a week, it is only a factor used to determine whether a self-directed job search was diligent.

d. Benefits from November 1, 2014 through May 9, 2017.

Petitioner is seeking maintenance benefits from November 1, 2014, the date Petitioner's employment with George A. Kennedy & Associates, Ltd. terminated, through the date of the trial, May 9, 2017. For the reasons stated above in section (d), the Arbitrator finds the Petitioner is not entitled to maintenance from November 1, 2014 through May 9, 2017.

3. Temporary Partial Disability Benefits from April 15, 2014 to October 31, 2014

Petitioner is seeking Temporary Partial Disability Benefits for the period he worked for George A. Kennedy & Associates, Ltd. Petitioner worked for George A. Kennedy & Associates, Ltd., from April 15, 2014 through October 31, 2014. During this time, Petitioner was at MMI. Petitioner was hired as an assistant project coordinator earing $2,333.33 per month. (Px. 17) Petitioner testified his girlfriend's father owned the company that hired him. (Tr. 75) Petitioner testified he only worked for approximately 6 months and his employment was terminated because work dried up. (Tr. 74) Documents from George Kennedy and Associates indicates the job was for a temporary position with a termination date of October 31, 2014. (Px 17) Mr. Patsavas testified Petitioner's job at George Kennedy only required a high school degree and Petitioner had no opportunity for advancement. The position was well below his earning capacity and the positon was not permeant. (Rx. 1, pgs. 66-68, 71-72, 77). Petitioner acknowledged he was overqualified for the positon. (Tr. 155) Mr. Grzesik disagreed. (Px.16 pgs. 51-54). The Arbitrator finds the opinions of Mr. Patsavas more persuasive then the opinions of Mr. Grzesik. The Arbitrator finds the employment at George A. Kennedy & Associates, Ltd., was not suitable employment and, therefore, Petitioner failed to prove by the preponderance of the evidence he is entitled to Temporary Partial Disability Benefits pursuant to Section 8(a) of the Act from April 15, 2015 through October 31, 2014. Therefore, Petitioner's claim for TPD is denied.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner asserts he is completely disabled and permanently incapable of work under an odd-lot category pursuant to Section 8(f) of the Act. "A PTD award is proper when an employee can make no contribution to industry sufficient to earn a wage." *Lenhart v. Workers' Compensation Comm'n*, 2015 IL App (3d) 130743WC. "A person is not entitled to PTD benefits if he or she is qualified for and capable of obtaining gainful employment without seriously endangering his or her health or life." Id. "The odd-lot category for purposes of a PTD award arises when a claimant's disability is limited in nature so that he obviously unemployable, or if there is no medical evidence to support a claim of total disability. *Id at 33* (Quoting *Valley Mould & Iron Co. v. Industrial Comm'n*, 84 Ill. 2d 538, 546-47 (1981)). The claimant ordinarily satisfies his burden of proving 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, skill, training and work history, he will not be regularly employed in a well-known branch of the labor market. *Id. At 37* (Quoting *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544 (2007). If the claimant establishes that he fits into the odd-lot category, the burden shifts to

the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Id*

The Arbitrator finds the Petitioner failed to establish by the preponderance of the evidence that he is not capable of obtaining gainful employment. Petitioner does not fall into the odd-lot category. Petitioner's own vocational counselor, Mr. Grzesik, testified Petitioner should have additional vocational services because, he believes, Petitioner currently could find a job. (Px 16, pgs. 117,118) Mr. Patsavas testified Petitioner currently qualifies for 90% of the job market because of Petitioner's abilities and capabilities which include being qualified to perform heavy duty work, Petitioner's transferable skills and prior work history. (Rx.1, pg. 39) Subsequent to his work related injury, Petitioner had the capability to attend college, earn a degree in finance, maintain a 3.99 GPA out of 4.0 and to golf every other day while 12-14 handicap. Clearly, Petitioner is capable for obtaining gainful employment and contributing to industry sufficient to earn a wage.

Regarding Petitioner's job search, Petitioner testified that he limited his job search, after vocational rehabilitation services ended. (Tr. 71) Mr. Patsavas advised Petitioner to lower his salary expectations to $50,000.00 to $60,000.00 salary range to increase the number of possible job opportunities. Mr. Patsavas testified Petitioner's asking price of $80,000.00 to $100,000.00 is to high for what Petitioner was bring to the table and that is why it needed to be lowered. (Rx. 1, pg. 178) Mr. Grzesik testified Petitioner's salary should be lower than $50,000.00. (Px 16, pg. 27) After vocational rehabilitation services ended, Petitioner only applied for executive jobs earning between $80,000.00 to $100,000.00. Petitioner's decision to disregard the recommendations of the vocational counselors and to eliminate multiple categories of potential jobs was an inappropriate limitation, making his self-directed job search meaningless and, therefore, not diligent.

Petitioner placed additional limitations upon his job search rendering it ineffective. Petitioner testified he only wanted executive position earning a certain amount because he did not want to do anything physical anymore. (Tr. 156) Petitioner acknowledged the FCE released him back to work at a heavy-duty level (Tr. 152), yet Petitioner testified he was not looking for jobs with heavy physical demands. (Tr. 157) Petitioner testified he directed his job search to those commensurate with his newly obtained college degree. (Tr. 158) During cross examination, Petitioner was asked whether he was looking for jobs that involved physical demands of medium or heavy level and Petitioner responded he was looking for jobs within his educations experience. (Tr. 158, 159) Petitioner testified he can't do physical labor anymore and he is not going to do anything physical anymore. (Tr. 156, 157) Petitioner testified he did not include jobs with a salary range of $40,00.00 to $60,000.00 in his job search because Petitioner did not want to do physical labor. (Tr. 156)

Based upon the above, the Arbitrator finds that Petitioner's job search was rendered ineffective by his own actions by not applying to entire categories of jobs within his restrictions. The Arbitrator finds Petitioner's conduct demonstrated bad faith intended to avoid finding employment. The intention of vocational rehabilitation is to return Petitioner to work not to return Petitioner to the new career of his choice.

A wage differential award is appropriate when, after the accidental injury has been sustained, the claimant as a result thereof becomes partially incapacity from pursuing his usual and customary line of employment. *Lenhart v. Workers' compensation Comm'n*, 2015 IL App (3d) 130743WC. "The object [of section 8(d) 1] is to compensate the injured employee for his reduced earning capacity, but if the injury does not reduce his earning capacity, he is not entitled to such compensation. *Franklin County Coal Co. v. Industrial Comm'n*, 398 Ill. 528, 532 (1948). 'The test is the capacity to earn, not necessarily the amount earned.' *Franklin County Coal Co.*, 398 Ill. at 532.

Dr. Aribindi, who perform an independent medical examination on July 11, 2016, after reviewing the history, medical records, imaging studies, surveillance and examining Petitioner, opined that Petitioner was capable for performing work at the heavy-duty level as an iron worker. (Rx 3)

Dr. Marra testified Petitioner could go back to work as an ironworker if Petitioner abides by his restrictions. (Px. 20, pgs. 16, 23, 30) Dr. Marra testified the restrictions are those outlined in the FCE dated of April 9, 2010. (Px. 20, pg. 33) Dr. Marra testified he reviewed a 5-minutes edited video Petitioner provided to him. Dr. Aribini testified he did not review the entire 5 hour surveillance videos. Dr. Marra testified he did not recall seeing Petitioner carrying bags of mulch in the edited version of the surveillance video. (Px. 20., pg. 42) The Arbitrator reviewed all of the surveillance videos and compared the surveillance videos to the 5 minute edited video provided to Dr. Marra. (Petitioner's exhibit #20). The Arbitrator notes various physical activities Petitioner was performing on the full surveillance videos were not incorporated into the 5-minute edited video provided Dr. Marra including Petitioner, on June 2, 2016, unloading bags of mulch from a dark color vehicle and carrying two bags of mulch at one time and Petitioner assisting landscapers unloading large trees from a truck, transporting the trees using a large handcart and assisting the planting of the trees on April 13, 2017. Additionally, Mr. Marra was unaware the amount of golf Petitioner was playing. Dr. Marra testified he was aware Petitioner played golf but he did not know any specifics. (Px 20, pg 39) Regarding the frequency of golf Petitioner played, Dr. Marra testified "I haven't looked at any of that." (Px. 20, pg. 39) Petitioner told Dr. Aribini he played golf every other day. (Rx. 3)

Based upon the above the Arbitrator finds the opinions of Dr. Aribini more persuasive than Dr. Marra regarding whether or not Petitioner could go back to work as an iron worker. Therefore, the Arbitrator finds the Petitioner failed to prove he is partially incapacity from pursuing his usual and customary line of employment.

The Arbitrator finds Petitioner sustained compensable bilateral shoulder injuries, which resulted in two surgeries to each shoulder. Dr. Marra found Petitioner reached MMI on April 20, 2010 and that Petitioner could work at the physical demand level pursuant to the FCE dated April 9, 2010. No subsequent FCE has ever been done. Respondent's IME, Dr. Aribindi, examined Petitioner on July 11 2016 and opined Petitioner had full strength, good range of motion and he could work full duty without restrictions as an iron worker. Based on the above, and the Record, taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 30% loss of use of a man as a whole pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (M) IS PETITIONER ENTITLED TO AN AWARD OF PENALTIES, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner requested an award of penalties pursuant to Sections 19(l) and 19 (k) of the Act and costs under Section 16 of the Act. The FCE, dated April 9, 2010, found Petitioner capable of working at the heavy level and could perform his job as an iron worker and Dr. Marra found Petitioner to be at MMI on April 10, 2010. Respondent paid maintenance benefits after Petitioner reached MMI, provided two years of vocational rehabilitation services and paid PPD advances from August 13, 2013 through March 10, 2014 and two additional PPD advances totaling $11,000.00 on 6/15/2016 and 10/18/2016.

The Arbitrator has found the Petitioner had improperly limited his self-directed job search and was playing significant amount of golf which impeded the Petitioner's job search. Based upon the totality of the circumstances, the Arbitrator does not find Respondent's conduct unreasonable. Therefore, the Petitioner's request for penalties is hereby denied.

WITH RESPECT TO ISSUE (O) PETITIONER'S VOCATIONAL REHABILITATION EXPENSES, PROSPECTIVE MEDICAL CARE AND RESPONDENT'S CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

1. Prospective Medical

Petitioner is seeking prospective medical treatment. The Arbitrator finds Petitioner does not require any further medical treatment related to the accident on January 28, 2008, as he has previously reached MMI as of April 2010. Both Dr. Aribindi and Dr. Marra have opined that no further related medical treatment is recommended. Accordingly, the Arbitrator finds no prospective treatment is awarded.

2. Vocational Expenses

Petitioner is seeking reimbursement of $41,665 plus interest on a loan for the cost of the degree from DePaul University. Petitioner enrolled into college before he was at MMI and before vocational rehabilitation services were retained. To determine whether a vocational rehabilitation award would include the cost of a degree various factors must be considered, such as is there a specific job sought, is a degree required, evidence of jobs available in the field sought given Petitioner's age, experience, background, physical limitations and whether other position Petitioner might be qualified for with other remedial or vocational training. *Hunter Corporation v. Industrial Comm'n*, 86 Ill.2d 489, 427 N.E. 2d 1247 (1981). In the instant case, Petitioner failed to present any evidence regarding the factors identified by the Supreme Court in *Hunter*. Therefore, Petitioner's request for reimbursement of the cost of his degree from DePaul University and interest is hereby denied.

3. Credits

Respondent shall be given a credit of $ of $117,000.00 for TTD, $0 for TPD, $172,000.00 for maintenance, and $29,448.35 for PPD advances, as identified in Respondent's Exhibit #4, for total credit of $318,448.35.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joyce Simon,
Petitioner,

vs.

NO: 15WC 8836

East Moline School District. #37,
Respondent.

18IWCC0452

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 27, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that 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: JUL 20 2018
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

SIMON, JOYCE
Employee/Petitioner

Case# **15WC008836**

EAST MOLINE SCHOOL DIST #37
Employer/Respondent

18IWCC0452

On 6/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1367 HOPKINS & HUEBNER PC
PAUL SALABERT JR
100 E KIMBERLY RD SUITE 400
DAVENPORT, IA 52806

1680 CASSANO & ASSOCIATES
BRIAN BENDOFF
1240 IROQUOIS AVE SUITE 210
NAPERVILLE, IL 60563

18IWCC0452

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Joyce Simon
Employee/Petitioner

v.

East Moline School Dist. #37
Employer/Respondent

Case # **15** WC **8836**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **February 7, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0452

FINDINGS

On the date of accident, **5/1/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 **$20,035.08**; the average weekly wage was **$385.29**.

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

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

Respondent shall be given a credit of **$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 establish that she sustained accidental injuries which arose out of and in the course of her employment with Respondent 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

6/16/17
Date

ICArbDec19(b)

JUN 27 2017

FINDINGS OF FACT

Petitioner began working for Respondent in 2005, and continued working until she was placed on leave in November 2014. She performed kitchen duties, which she described in detail. Her job duties included working a computerized register for school children to purchase food, cleaning dishes, preparing sandwiches, and preparing salads. Petitioner testified she worked each specific job on a monthly basis, performed the monthly duties as described in PX 10 only 2 ½ hours per day on average, and spent the remainder of her shift assisting with the service of food to schoolchildren. Petitioner's job was part time, and she did not work during the summer months.

Petitioner had a prior medical history of uncontrolled diabetes and hand pain for many years preceding the alleged accident date in this case. On February 28, 2011 she presented to Deanne Hobert, APN for a diabetes recheck (PX 1). Petitioner testified only her right hand was bothering her. Ms. Hobert's records reflect a diagnosis of "bilateral hand and wrist pain," and "diabetes mellitus type 1. Uncontrolled." (PX 1). Ms. Hobert's note further reflects that "[Petitioner] states she works with her hands washing dishes throughout the day." (PX 1). Petitioner testified she told Ms. Hobert about all of her job duties, and that she was truthful and accurate when speaking to her medical providers. She testified Ms. Hobert's records do not reflect an accurate description of her job duties.

On March 14, 2011, Petitioner was seen again by Ms. Hobert in follow-up for her bilateral wrist pain. (PX 1). She was told to continue wearing wrist braces for wrist pain. Petitioner testified she took off the wrist braces before work and put them back on after work. No one at work instructed her to remove her wrist braces. She did not offer any evidence that Respondent knew she was given wrist braces to wear at that time.

On December 5, 2011 Petitioner returned to Ms. Hobert complaining of bilateral hand pain. Ms. Hobert's notes reflect no injury, stating "Context: there was no injury." (PX 1).

On September 4, 2012, Petitioner returned to Community Health and was seen by Dr. Mukesh Kumar. The note generated by Dr. Kumar reflects an HPI of "follow up from ER," further noting that Petitioner had been "admitted to hospital for DKA [diabetic ketoacidosis]" and had bilateral hand pain, "aggravating factors include work." (PX 1). Nursing comments note that "blood sugars are out of control…" (PX 1). Petitioner was instructed to follow up with Dr. Kumar for "carpal tunnel synd." (PX 1). At trial, Petitioner testified she did not follow up. On cross examination, she testified that she believed her work duties were the cause of her hand pain at the time of her visit to Dr. Kumar in September 2012. Petitioner also testified during cross examination that she did not contact either Human Resources or the Director of Food Services at that time.

A brief unrelated follow-up on December 10, 2012 with Dr. Kumar notes "carpal tunnel syndrome" and "Body Mass Index 30.0-30.9, Adult." (PX 1) No off-work notes or restrictions were written at any time in 2011 or 2012. The records do not reflect a history of repetitive job duties, or that Petitioner's job was a causal factor in her pain.

Petitioner testified she gave notice to Respondent on May 1, 2013, claiming she had separate meetings that date with Colin Kave, Christine Mueller, and Superintendent Kristin Humphries, during which she expressed concern with her hands. Yet she requested additional work hours at that time in order to obtain health

insurance. She claimed that she repeatedly expressed, "look at my hands, look at my hands" during each of these meetings. Petitioner did not testify that she notified her colleagues that she believed her medical condition was related to work.

Colin Kave and Christine Mueller both testified they did not recall any such meeting with Petitioner, either on May 1, 2013 or at any time. Ms. Mueller testified that if Petitioner had reported a work injury, she would have been given a work injury form to complete and submit promptly. Both Mr. Kave and Ms. Mueller testified the Company requires injured workers to report work injuries promptly. If Petitioner had reported a work injury on May 1, 2013, Ms. Mueller testified, she would have been given a work injury form to fill out and submit at that time. Work injuries in the district are handled through Ms. Mueller's office.

Petitioner did not prepare a work injury report form until July 20, 2014, and Respondent did not receive it until August 13, 2014. (RX 2). Respondent immediately prepared a First Report of Injury (Form 45) same day, August 13, 2014. (RX 4).

Petitioner testified she had a conversation with Superintendent Kristin Humphries on or about May 1, 2013 and relayed that she'd been diagnosed with carpal tunnel syndrome and needed surgery. On cross examination, Petitioner's testimony was different in that she testified that she was not diagnosed with carpal tunnel syndrome until 2014, and did not receive a recommendation for surgery until 2014.

Petitioner began treating for her alleged work related hand pain with Dr. Peter Alward on May 1, 2014. (PX 2). She had not sought treatment for hand pain since December 10, 2012. Dr. Alward diagnosed bilateral carpal tunnel syndrome, and recommended an EMG nerve conduction study. An EMG was later performed May 13, 2014. (PX 3). Dr. Alward reviewed the test and on July 3, 2014 referred Petitioner to Dr. VonGillern for further evaluation.

On July 21, 2014, Petitioner was seen by Dr. Thomas VonGillern. (PX 2) She complained of bilateral hand pain, and noted her symptoms were made worse with lifting activities. (PX 2) The record does not reflect Petitioner's job duties. On cross examination, Petitioner testified she informed each of her physicians of her work duties. She claimed that her medical records did not correctly reflect those work duties. Petitioner does not work during the summer months, and she was not working for Respondent when she first saw Dr. VonGillern in July 2014. A surgical recommendation was made. (PX 2)

It was around that same time Petitioner completed her report of injury form for Respondent, dated July 20, 2014. (RX 2). An East Moline School District stamp on the exhibit reflects a receipt date of August 13, 2014. Respondent's Exhibit 4 - Respondent's First Report of Injury Form - notes the injury was first reported August 13, 2014.

Petitioner testified she saw Dr. VonGillern on October 20, 2014, and he provided her a temporary restriction Respondent could not accommodate.

Petitioner provided electronic correspondence she wrote to the Superintendent asking for medical leave, dated November 14, 2014. That correspondence does not reference any work related accident or condition. (PX 5).

18IWCC0452

Petitioner was last seen by Dr. VonGillern on December 11, 2014. Reportedly she was "still waiting for work comp to approve her surgery." (PX 2). Petitioner testified that her medical care was previously paid out-of-pocket or by Public Aid. None of her medical providers submitted bills for services rendered to Respondent's Workers' Compensation Carrier before December 11, 2014.

Petitioner was seen by Respondent's Section 12 medical examiner, Dr. David Fletcher, on November 15, 2015. (RX 1). In addition to performing an examination of Petitioner, Dr. Fletcher also reviewed the medical records including those from Community Health, Dr. Kumar, and Dr. Alward.

Dr. Fletcher concluded that "this is clearly not a work related issue. She is less than full time and does not work in the summers." Further, he opined that "It is significant that her condition has gotten worse away from her alleged ergonomic exposure....Her present condition is easily explained by her poorly controlled diabetes." (RX 1).

Petitioner admitted that her condition worsened even when she was not working. She testified that her fingers began to curl into a fist. At the hearing however the Arbitrator observed that she did not appear to have difficulty shaking hands.

Dr. VonGillern drafted a letter dated May 26, 2016, expressing the opinion that "the patient's medical evaluation and proposed surgical treatment were at least aggravated by her on-the-job working activities." (PX 4).

CONCLUSIONS

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
Issue (D): What was the date of the accident?
Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner claimed she sustained a compensable accident that arose out of and in the course of her employment with Respondent on May 1, 2013; and that her condition of ill-being is causally related to the accident.

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

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

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

Although a claimant is aware of symptoms and carries a suspicion that these are work-related, the Supreme Court has stated, "The 'fact of injury' is not synonymous with the 'fact of discovery'" *Durand,* N.E.2d at 927. Claimants are not charged with filing a claim as soon as they believe they may have a work-related condition, nor are they penalized for failing to realize a condition is work-related when the employer feels that he or she should have. The Supreme Court stated that to rely solely on a claimant's testimony concerning symptoms, without accurate knowledge of the cause of those symptoms, would essentially be asking them to "rely on 'expert' medical testimony from a layperson." *Id.* at 929. The Court also recognized that claimants would have had difficulty proving injury with a sketchy and equivocal understanding of the cause of their symptoms. *Id.* at 930. The standard that "the 'fact of injury' is not synonymous with the 'fact of discovery'" has since become a safety measure employed by all Courts to ensure that the employers do "penalize an employee who diligently worked through" his or her symptoms. *Durand v. Indus. Comm'n*, 862 N.E.2d at 927, 930. In *Durand*, the claimant was not sure her pain was from carpal tunnel syndrome, but "she believed it was work-related" in 1997, some 3 years before her injuries manifested in 2000. *Durand v. Indus. Comm'n*, 862 N.E.2d at 929-30.

In *Oscar Mayer*, the Court embraced the "date of collapse" method of determination, setting the manifestation date on the date of surgery, or the date the employee could no longer work. Compensation was awarded to a claimant, despite his full knowledge that his condition was work-related well before he filed a

claim, because the claimant diligently served his employer until he could no longer do so without intervention for his repetitive injuries. *Oscar Mayer supra.* The Court noted that no prejudice can occur in employing such a method, since it is not until the employee actually misses work for his injuries that the employer becomes adversely affected; and the notice provisions were not impugned as this flexible and fair provision in no way interfered with an employer's ability to effectively investigate the claim.

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

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

In this case Petitioner asserts a manifestation date of May 1, 2013. However, the evidence in this case demonstrates that May 1, 2013 is not the date on which both the fact of the injury and the causal relationship between the injury and the employment were plainly evident to a reasonable person. That was not the date she first sought medical attention for her condition, not the date she was first informed by a physician that her condition was work related, not the date she was first unable to work as a result of the condition, not the date when the symptoms became more acute at work, and not the date she first noticed the symptoms of her condition.

Further, the Arbitrator notes Petitioner did not seek any medical treatment between December 12, 2012 and May 1, 2014.

Petitioner admitted to having a 26 year history of diabetes. The earliest medical records tendered reflect a history of "Diabetes mellitus Type 1. Uncontrolled" (PX1). On September 4, 2012, the record reflects that Petitioner was hospitalized due to diabetic ketoacidosis.

Petitioner's treating physician, Dr. VonGillern, drafted a letter on May 26, 2016 in which he opined simply that Petitioner's medical condition and proposed treatment were aggravated by her work. There is no indication of the depth of the doctor's understanding of the specific activities which the job entailed.

Respondent's Section 12 Examiner, Dr. David Fletcher, reviewed Petitioner's medical records dating back to 2010, which Dr. VonGillern did not do. Despite not having EMG results to review, Dr. Fletcher concurred with Dr. VonGillern's diagnosis and plan for future care. However, Dr. Fletcher gave consideration to Petitioner's ergonomic factors, co-morbidities, and previous medical history while Dr. VonGillern apparently

failed to do so. Additionally, Dr. Fletcher considered the fact that Petitioner's symptoms worsened after the cessation of her job activities in determining the causal relationship between Petitioner's condition of ill-being and her job. Dr. Fletcher explained "this is clearly not a work related issue. She is less than full time and does not work in the summers." Further, he opined that "It is significant that her condition has gotten worse away from her alleged ergonomic exposure....Her present condition is easily explained by her poorly controlled diabetes." (RX 1).

The Arbitrator finds the opinions of Dr. Fletcher more persuasive in this case.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner has failed to establish that she sustained accidental injuries which arose out of and in the course of her employment with Respondent, and has further failed to establish that her current condition of ill-being is related to a work accident or exposure. Benefits are, therefore denied. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Jo Alsup,
Petitioner,
vs.

NO: 12WC 36198

18IWCC0453

Larry H. Rapp, DDS.,
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, 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 26, 2017, is hereby affirmed and adopted.

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

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

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: JUL 20 2018
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALSUP, MARY JO
Employee/Petitioner

Case# **12WC036198**

LARRY H RAPP DDS
Employer/Respondent

18IWCC0453

On 10/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% 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:

2346 CHATHAM & BARICEVIC
CHARLES BARICEVIC
107 W MAIN ST
BELLEVILLE, IL 62220

0725 LAW OFFICE CRAIG A HANSEN
ANDY KOVACS
3660 S GEYER RD SUITE 340
ST LOUIS, MO 63127

18IWCC0453

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

Mary Jo Alsup
Employee/Petitioner

v.

Larry H. Rapp, DDS
Employer/Respondent

Case # 12 WC 36198

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 27, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 14, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$27,859.00**; the average weekly wage was **$535.73**.

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$321.44/week** for **0 weeks**, because the injuries sustained caused **0%** loss of the **person as a whole**, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

10/24/17
Date

OCT 26 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Mary Jo Alsup
Employee/Petitioner

Case # 12 WC 36198

v.

Consolidated cases: N/A

Larry H. Rapp, DDS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she is not currently employed and that her last place of employment was that of Respondent, where she worked until 2011. She testified that back in November of 2011, it was her job to refill small containers that held Cavicide, a disinfectant, and that it came in a 2½ gallon jug. She testified that on November 14, 2011, she went to pick the jug up off the floor and felt a pop in her back, and that the pain occurred in her upper back. She testified that she stayed a couple of more hours at work that day.

Petitioner testified that she sought medical care maybe 1-1½ months after the incident. She testified that her primary care physician at that time was Dr. Tang and that he was no longer practicing but that he had an office in Fairview Heights. She testified that her current primary care physician was Dr. Shenouda, who took over Dr. Tang's patients. She testified that she saw Dr. Shenouda within a couple of months of the accident. When asked if she recalled seeing Dr. Shenouda for blood in her urine in February of 2012, Petitioner responded affirmatively and stated that she brought up the injury and was told that she would need a claim number to see him for medical treatment for her back. Petitioner testified that she did not go to the emergency room after she was injured because she could not afford it and that her deductible was $500. When asked how she paid for Dr. Shenouda's visits, Petitioner responded that she saw Dr. Shenouda for other things and that at those visits, she asked him about treating her for her back. She testified that he referred her to Dr. Yi and that Dr. Yi sent her for an MRI at Barnes Hospital. She testified that she also saw Dr. Thom, a second referral from Dr. Shenouda.

Petitioner testified that she recalled getting in a motor vehicle accident in 2012 when she swerved to avoid a deer and ran into a ditch. She testified that she went to the hospital via ambulance and that they did a CT of her head and neck. She testified that the ambulance took her from the accident scene to the hospital.

When asked if she recalled having pain in her back prior to the injury at Dr. Rapp's office, Petitioner testified that she did not have pain in her upper back. She testified that she was very active and that along with working, she had a regular walking regimen. She testified that she continued to work for Dr. Rapp for another 8-9 months after the accident and that she did most of her work on her feet and did not sit too much. She testified that she stopped working after her primary care physician called Dr. Rapp and told him that he was required to give Petitioner a claim number and that Dr. Rapp was very belligerent and cursed at her. She testified that she tried to continue working through that, but did not understand.

Petitioner testified that she continued to treat with Dr. Shenouda after Dr. Tang retired. She testified that she was treating with Dr. Shenouda in 2012 after her motor vehicle accident and that she notified him of the accident in 2012. She testified that after the motor vehicle accident, her pain was the same and that nothing was different. She testified that she was aware that she has a "degenerative spinal column" and denied having any of the symptoms that she is complaining of now in her back prior to the accident.

On cross examination, Petitioner agreed that she continued to work through August of 2012, which was about nine months after her alleged accident. She agreed that she was claiming temporary total disability benefits since the date of accident in 2011, but that she continued to work until 2012.

On cross examination, Petitioner denied that the first time she saw Dr. Shenouda for this accident was on August 28, 2012 and testified that she had talked to him about the accident prior to then. She testified that in between seeing Dr. Thom in January of 2014 and having been seen by Dr. Shenouda in 2012, Dr. Shenouda referred her to Barnes Hospital where she had an MRI and back injections which did not help. She testified that the injections were in her upper thoracic region and were performed by Dr. Yi at Barnes Hospital.

On cross examination, Petitioner agreed that she went to the emergency room after the motor vehicle accident on August 25, 2012. She testified that she had the same concern about the deductible, but that the EMTs were concerned that she could have hurt something in her head and that they requested that she go. She agreed that she felt that it was urgent for her to go.

On cross examination, Petitioner testified that the jug of Cavicide was a 2½ gallon jug and was full when she picked it up. She denied knowing how much the jug weighed.

The Stipulation to Substitute Attorneys was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Attorney Representation Agreement was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The transcript of the deposition of Dr. William Thom taken on June 8, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Dr. Thom testified that he is board-certified in anesthesiology and pain management. He testified that he saw Petitioner at the referral of her primary care physician, Dr. Shenouda, on January 7, 2014. (PX3).

Dr. Thom testified that Petitioner had numerous areas of complaint and that her primary area of complaint was mid-back pain that radiated into the flank that she had had it for some time prior to his seeing her. He testified that Petitioner also complained of bilateral low back pain, leg and arm pain as well. He testified that his office had obtained a small amount of information from Dr. Shenouda but that they had most of their patient information about previous care from Petitioner and that the complaints were consistent with the complaints that Dr. Shenouda had reported that she had provided. He testified that Petitioner indicated that her primary complaint was related to a lifting accident that occurred while working and that he had no reason to disagree with the November 11, 2011 date of accident as provided by Petitioner's attorney. He testified that he was aware that Petitioner had been involved in a motor vehicle accident at some time in August of 2012. (PX3).

Dr. Thom testified that Petitioner seemed fairly limited by her chief complaint and that she appeared painful when he saw her. He testified that Petitioner indicated some limitations in her activities of daily living as well as her work activities and that she seemed on the whole fairly less optimistic about her overall case and prognosis. He testified that Petitioner had pain symptoms that began mid to low thoracic spine and wrapped into the flank and that she related that back to the lifting accident. He testified that Petitioner indicated some frustration with her care from that point on and was looking for someone to manage her symptoms and treat her pain. (PX3).

Dr. Thom testified that an MRI of the thoracic spine showed several disc herniations with T7-8, T8-9 and T9-10 specifically involved. He testified that these were uncommon. He testified that it was consistent with where Petitioner described her pain and that if they were going to see thoracic spine injuries, it would either be through trauma or through lifting or other stress-related injuries. (PX3).

Dr. Thom testified that he believed that degenerative changes in the spine were evident on x-ray but that he did not feel that they were related to her current symptoms. He testified that based on the description, based on the radiating pattern and based on the mechanism of injury, he did not believe those degenerative changes to be the result of her sudden onset of pain. (PX3).

Dr. Thom testified that the next follow-up visit was on February 24th, at which time Petitioner continued to report similar symptoms. He testified that Petitioner felt that the medications were mildly helpful but that she had similar symptoms noted. He testified that the tingling in the bilateral hands was not consistent with the diagnosis he described and that he considered it either an anxiety reaction or related to other pathology outside of the thoracic spine. He testified that he next saw Petitioner on March 19, 2014 for an injection. He testified that the next evaluation occurred on April 21, 2014 and that there was a nuclear medicine bone scan dated December 28, 2011 which indicated inflammation within the spine. He testified that while not a radiologist, his review of the film indicated some increased uptake at the lower thoracic spine which would be potentially consistent with inflammation, which could be consistent with the acute disc injury Petitioner described. He testified that he opined that based on Petitioner's report, mechanism of injury, description of pain and imaging studies, he had no doubt that her pain was a direct and persistent result of the lifting injury that occurred in November of 2011 and indicated that he was referring to her primary complaint of mid back pain radiating to the flank. He agreed that he was aware of the motor vehicle accident and considering the motor vehicle accident, he still stood by that conclusion. (PX3).

Dr. Thom testified that thoracic spine injuries were not commonly seen following low-energy motor vehicle collisions. He testified that an individual could still have an acute injury in the thoracic spine alongside of degenerative issues in the back and that it may also increase the likelihood that one might develop a painful condition of the spine if there was preexisting disease. (PX3).

When asked if he had any estimation as to future treatment, Dr. Thom responded that Petitioner had been very responsive to epidural injections and that they could be repeated. He testified that physical therapy would also be advisable as long as Petitioner was having symptoms on a regular basis to try to minimize the symptomatic nature of her disease. He testified that the medications Petitioner was taking, barring any kind of spontaneous resolution of her symptoms, would likely be chronic and that she was taking prescription-strength opioid analgesics. He testified that in Petitioner's case thoracic disc surgery was very difficult, was very risky and was associated with very low outcomes so most surgeons would likely not offer a three-level thoracic fusion or discectomy. He testified that things that could be considered in the future should Petitioner's pain persist might be spinal cord stimulation or an intrathecal pain pump unless she were to get satisfactory benefit from more conservative treatment like the medications, physical therapy and injections. (PX3).

When asked to review the IME report of Dr. Petkovich, Dr. Thom testified that he disagreed with his conclusions as he was not referring to the MRI study so he assumed that he did not see the presence of the disc herniations at multiple levels which indicated to him the potential for acute injury at those levels and that it matched Petitioner's pain. (PX3).

On cross examination, Dr. Thom agreed that the first time that he saw Petitioner it was more than two years after her date of injury and initial onset of complaints. When asked if he knew what Petitioner alleged to have been lifting when she was injured, Dr. Thom responded that he believed it was a cleaning product by the name of Cavicide. He testified that he did not know how much it weighed, but that it may have been as little as 10 pounds. (PX3).

On cross examination, Dr. Thom testified that he did not know who ordered the bone scan but that he did see the film. He testified that a bone scan was not normally used to diagnose disc herniations and that he believed it was ordered for a different pathology and that it happened to show them. He testified that he believed that an MRI of the thoracic spine was performed but that he did not believe that he ordered it. He testified that the herniations of T7-8, T8-9 and T9-10 could be consistent a with degenerative process but could also be consistent with an acute process. He testified that the thoracic spine was the most stable structure of the spine and usually required some degree of trauma to get injury. (PX3).

On cross examination, Dr. Thom testified that he and Petitioner did not discuss her weight much. He agreed that Petitioner specifically denied any thoracic pain prior to the lifting incident in November of 2011 to him but admitted that he was not aware of any different history given to any other physician. He testified that Petitioner did come in with some low back pain and that that had been a chronic problem for her as well, but that he did not know the timing of it. He testified that it was his understanding that Petitioner worked for at least a few weeks if not longer before she quit her job but that he could not speak to that specifically without reviewing his records. When asked if he was aware of the length of time it took for Petitioner to seek medical treatment for her thoracic spine injury, Dr. Thom responded that she indicated to him that she had had some trouble getting care and that she was evaluated initially and then there were some physicians that were not willing to address her symptoms until she had received a claim number. He testified that it was all very vague and that it was discussed in January of 2014. (PX3).

On cross examination when asked about his reference to Petitioner having been reluctant to show up for injections, Dr. Thom testified that there were several instances during the course of treatment where she no-showed or cancelled appointments. He testified that he was not sure of the specifics as to why but that there were some correspondences that suggested possibly she just forgot or had a conflicting scheduled appointment. He testified that Petitioner had another appointment scheduled to refill her medications and that she was currently taking Nucynta. He testified that Petitioner had had physical therapy through his office but that he did not believe she was currently doing that. He testified that no additional injections had been ordered. (PX3).

On cross examination, Dr. Thom testified that he did not believe that Petitioner was at maximum medical improvement but that she was at a "stable place" and that she indicated on her last visit on June 2nd that she wanted to do some things but felt like she was being denied by her private insurance due to an open workers' compensation claim. When asked if he had any specific restrictions on Petitioner's activities at the time of the deposition, Dr. Thom responded that he did not think she was capable of working but thought that it had a lot to do with the combination of her symptoms. He testified that Petitioner had a hip arthropathy and ongoing thoracic pain. He testified that Petitioner had not worked while she had been with his office and they had not made specific comments on her ability to work, but that he was not sure that she could, when combined with her depression, hold down gainful employment. He testified that Petitioner also had arthritic conditions of the knees and hip and agreed that the depression, knees and hip were not related to the accident at issue. He testified that excluding the other conditions, he thought that Petitioner would not be able to do repetitive lifting, overhead work and heavy lifting due to her thoracic spine. He testified that he had a hard time envisioning Petitioner doing well at a job where she would have to do frequent pushing and pulling of any weight over 20-25 pounds either. (PX3).

On cross examination when asked if Petitioner could continue working the job for Dr. Rapp with just the thoracic spine-related restrictions, Dr. Thom responded that if she was limited to desk work then he did think she could do so but admitted that he did know if he fully understood her complete role with Dr. Rapp. He testified that if Petitioner were a dental hygienist, he would say no because of the sustained postures she would have to assume. He testified that if her job with Dr. Rapp required her to do extended overhead work, to lift, push, pull or carry pounds any greater than 20, then he would say no. (PX3).

On redirect when asked if Petitioner would be able to perform sedentary work for 40 hours a week if she were just sitting at a desk, Dr. Thom responded that he believed that she could if Petitioner was allowed to change position frequently and take frequent rests. He testified that Petitioner could potentially get around that with bracing and with aggressive physical therapy to maintain a more appropriate posture, but whether she was capable of that given all of her other conditions he did not know. (PX3).

The transcript of the deposition of Dr. Mounir Shenouda taken on January 27, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Dr. Shenouda testified that he is board-certified and his curriculum vitae demonstrates that he is board-certified in Internal Medicine. (PX4).

Dr. Shenouda testified that he first saw Petitioner in 2005, that he continues to treat her and that he last saw her personally on September 14, 2016. He testified that Petitioner had several different diseases and that she had osteoarthritis and degenerative disease of her spine. He testified that he was aware that Petitioner had an injury in November of 2011 but testified that he did not treat her right away but that she later came in for help. He testified that he finally saw Petitioner for her alleged work-related injury in May of 2012. He testified that Petitioner came in complaining of back pain and midback pain and that she had paraspinal spasm in the thoracolumbar area. He testified that he ordered an x-ray and pain medications and asked her to use a heating pad and to return in a few weeks if it was not any better. He testified that the films performed on July 21st showed multiple degenerative joint disease in the lumbar spine, which he referred to as a sclerotic focus. When asked if his review of the films was consistent with Petitioner's complaints, Dr. Shenouda testified that it was the same pathology and the same area. (PX4).

Dr. Shenouda testified that he next saw Petitioner on September 19th and that she was still having the same complaint. He testified that he wanted Petitioner to undergo an MRI and then refer her to pain management for physical therapy and possible epidural injections as well as to give her a stronger pain medication. He testified that he aware that Petitioner had been involved in a motor vehicle accident after she reported having a work-related injury. When asked whether that changed his opinion that the causation of her acute back injury was work-related, Dr. Shenouda responded that he could not say 100% yes and that he could not say 100% no. He testified that when one had a degenerative joint disease you got a little bit of instability in the back, so less injury could cause a problem or a herniated disc. (PX4).

Dr. Shenouda testified that when he authored a letter at Petitioner's request dated November 19, 2013 he did so almost two years after her alleged injury, but testified that he had been seeing her for over a year for that specific injury. He testified that he referred Petitioner to Dr. Thom, a pain management physician. He testified that he agreed with Dr. Thom's assessment that Petitioner's pain was a direct and persistent result of the lifting injury that occurred in November 2011. He agreed that he has continued to care for Petitioner as a general practitioner and that he was aware of all other health-related issues that she may have. (PX4).

On cross examination, Dr. Shenouda testified that he saw Petitioner between November 2011 and May 2012 on one occasion and that she did not mention the accident at issue at any time during that visit. He testified that Petitioner came in because she had blood in her urine and that she had a urine test only and that he did not see her personally. He testified that they checked Petitioner's urine, that it was a nurse visit and that she was sent for evaluation by a urologist. He testified that he next saw Petitioner on May 2nd. (PX4).

On cross examination, Dr. Shenouda testified that he saw Petitioner a couple of times between May 2, 2012 and September 19, 2012. He testified that when he saw Petitioner on September 19th, she had the same complaints. He testified that the visit on August 28th was for her back and that he did not think she had had the motor vehicle accident at that time. After having been informed by Petitioner's attorney that the motor vehicle accident occurred on August 25, 2012, he agreed that he saw Petitioner three days after the accident had occurred. He agreed that he ordered the MRI at the September 19th visit. (PX4).

On cross examination when asked what was his understanding of the injury Petitioner alleged to have suffered while working for the dentist's office, Dr. Shenouda testified that she carried something heavy and that she had pain. He testified that in terms of the trauma involved in the motor vehicle accident, he learned the specifics of the accident from the emergency room records. When asked if he could differentiate between what happened to Petitioner in terms of aggravating her degenerative joint disease in the November work accident versus the August 2012 motor vehicle accident, Dr. Shenouda responded that if Petitioner complained about the pain before that was from the workers' compensation claim and that if she complained of the pain or new pain after the motor vehicle accident, then that would be from the motor vehicle accident. (PX4).

The medical records of Dr. Mounir Shenouda were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Included within the records was a letter dated November 19, 2013[1] noted that Petitioner had an injury in November 2011 that was being handled by workers' compensation and that the first visit to his office for the injury was August 28, 2012 but that she had had pain from the injury since November 2011. The document dated April 21, 2014[2] was apparently authored by Dr. Thom and noted a chief complaint of bilateral low back and T-spine pain radiating into the right arm. It was noted that Petitioner returned one month following right T7-8 and T8-9 transforaminal epidural steroid injection under fluoroscopic guidance and that she reported nearly 100% reduction in her symptoms until 2 or 3 days ago when she began coughing secondary to upper respiratory infection. It was noted that Petitioner continued to have pain relief but had now had to return to oral medications for satisfactory control. It was noted that given Petitioner's dramatic response to the procedure and failure to respond to others that were less selective, Dr. Thom thought that the diagnosis had been confirmed and that it was safe to say that Petitioner was suffering from T8/9 thoracic radiculopathy as a direct result of her on-the-job injury dated November 14, 2011. It was noted that Petitioner described pain since this injury immediately after lifting a heavy object from the floor and that she although she suffered injuries during a motor vehicle accident several years later, her description had been consistent and there was documentation of her efforts to pursue care for thoracic back pain prior to the motor vehicle accident. It was noted that Dr. Thom would personally review the nuclear medicine bone scan results and comment on those in the future and that in the meantime, Petitioner would continue to be off work at his recommendation. (PX5).

The radiology reports from Dr. Mounir Shenouda were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent an MRI of the thoracic spine on September 27, 2012 at Memorial Hospital, which was interpreted as revealing multilevel degenerative changes including a large right paracentral disc extrusion at T7-T8 which indents the right anterior aspect of the spinal cord, however, there is no significant central spinal canal or neural foraminal stenosis seen on this exam; no spinal cord compression. Petitioner also underwent another MRI of the thoracic spine on April 15, 2016, which was interpreted as revealing stable moderate thoracic spondylosis with several disc herniations; no resultant spinal canal or foraminal stenosis. (PX6).

The medical records of Associated Physicians Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was seen on January 7, 2014, at which time it was noted that her chief complaint was that of bilateral low back and T-spine pain radiating into the right arm and left leg x two years. It was noted that Petitioner stated that she hurt herself bending over at work picking up a 2.5-gallon jug of Cavicide, that she reported that she felt something pop in her back and that the pain immediately began radiating through the front of her chest and around to the chest from the thoracic spine. It was noted that Petitioner had difficulty taking full breaths and that there was an intense pressure sensation/spasm in her mid to low back and chest at the time. It was noted that Petitioner had difficulty getting out of chairs as well as getting out of bed and that she had the pain for one week

[1] The letter contained an "Exhibit 2" sticker which was not placed there by the Arbitrator.
[2] The document contained an "Exhibit 3" sticker which was not placed there by the Arbitrator.

before she realized that it was not going to simply resolve spontaneously. It was noted that Petitioner reported making an appointment with her company's occupational medicine physician but that she went to the doctor and they denied her because she did not have a "workman's comp id number." It was noted that Petitioner's primary care physician, Dr. Shenouda, eventually obtained an x-ray which showed no fracture. It was noted that Petitioner reported working with the pain the entire time and that she was denied physical therapy or additional care. It was noted that Petitioner continued to have pain in the same distribution, that she complained that stairs made her pain worse and that leaning backwards worsened the pain. It was noted that Petitioner wished to discuss possible injections. It was also noted that Dr. Thom believed that the mechanism of injury, symptoms and physical exam findings were all congruent and pointed to persistent pain from a work-related injury that resulted in thoracic disc injury and thoracic radiculitis. It was noted that Petitioner denied significant back or mid back pain requiring treatment prior to this injury. Petitioner was recommended to undergo a trial of right T8-9 and T9-10 thoracic epidural steroid injections under fluoroscopic guidance. Petitioner was prescribed medications and was referred to physical therapy. Petitioner was also ordered to undergo a fitting of an Aspen TLSO. (PX7).

The records of Associated Physicians Group reflect that Petitioner was seen on February 24, 2014, at which time it was noted that she had cancelled her original follow-up appointment one month earlier and indicated that she was not currently doing physical therapy nor had she received her brace due to waiting on authorization. It was noted that Petitioner complained that if she leaned her head back, she would get dizzy and lightheaded. It was noted that Petitioner wished to discuss injections and that she stated that her pain was in the middle of the mid back and that she had numbness and tingling in the bilateral hands. Petitioner was scheduled to undergo right thoracic transforaminal epidural steroid injections at T7-8 and T8-9 under fluoroscopic guidance to treat her symptoms of radiculitis/radiculopathy, which were performed on March 19, 2014. Petitioner was instructed to continue physical therapy and/or chiropractic management and she was again ordered for a fitting of an Aspen TLSO. (PX7).

The records of Associated Physicians Group reflect that Petitioner was seen on April 21, 2014, at which time it was noted that she returned one month following right T7-8 and T8-9 transforaminal epidural steroid injection under fluoroscopic guidance. It was noted that Petitioner described nearly 100% reduction of symptoms until two or three days ago when she began coughing secondary to upper respiratory infection. It was noted that Petitioner continued to have pain relief but now had to return to oral medications for satisfactory control. It was noted that given Petitioner's dramatic response to the procedure and the failure to respond to others that were less selective, Dr. Thom thought that the diagnosis had been confirmed and that it was safe to say that Petitioner was suffering from T8/9 thoracic radiculopathy as a direct result of her on-the-job injury dated November 14, 2011. It was noted that Petitioner would continue to be off work at Dr. Thom's recommendation. At the time of the May 12, 2014 visit, it was noted that Petitioner returned with a recurrence of her thoracic spine pain related to disk herniation at T7-8 sustained during a lifting injury at work. It was noted that Petitioner would be scheduled to repeat an epidural steroid injection in an effort to obtain more lasting benefit. It was noted that Dr. Thom thought that Petitioner was a candidate for physical therapy and thoracolumbar support orthotic to help her to tolerate activity and potentially return to work. Petitioner was recommended to undergo a diagnostic ultrasound evaluation of her left anterior and posterolateral hip to evaluate for and localize inflammation or soft tissue periarticular pathology as well as x-rays of the left hip to evaluate for osteopathy/arthropathy as a source of Petitioner's complaints of regional pain. Petitioner was also recommended to be scheduled for right T7-8, T8-9 facet joint epidural steroid injections under fluoroscopic guidance to treat symptoms of radiculitis/radiculopathy. (PX7).

The records of Associated Physicians Group reflect that Petitioner was seen on June 30, 2014, at which time the chief complaint was noted to be that of mid thoracic pain radiating into the right arm. It was noted that Petitioner wanted an injection and that she also complained of left hip and knee pain and wanted this pain to be addressed as well. It was noted that Petitioner was willing to start physical therapy and that she needed a medication refill. Petitioner was ordered to undergo x-rays of the bilateral hips and

bilateral knees as well as a diagnostic ultrasound examination of the left anterior and posterolateral hip and left knee. Petitioner was also ordered to undergo physical therapy. (PX7).

Included within the records of Associated Physicians Group was a Physical Therapy Evaluation which was performed on January 20, 2014 for a chief complaint of low back and thoracic pain. It was noted that Petitioner rated her upper back pain at 6/10, that the pain was located between the shoulder blades and that it could radiate into the right upper extremity as well as into the sternum. It was noted that Petitioner noted significant fatigue into the bilateral upper extremities with prolonged use and an abnormal sensation of numbness/tingling into the 4th and 5th digits on each hand. It was noted that Petitioner also complained of low back pain at 4/10 and that the pain was located into the bilateral lumbar region and could radiate into the left hip. (PX).

Included within the records of Associated Physicians Group was a Work Status Report dated April 28, 2014, taking Petitioner off work until the next visit on May 19, 2014. A Correspondence note dated March 13, 2014 noted that Petitioner's daughter called and stated that Petitioner fell down the stairs the day before and was in severe pain and would like to see Dr. Thom. It was noted that Dr. Thom stated that Petitioner needed to go the emergency room if she was in severe pain or needed to speak with her primary care physician. (PX7).

The DVD of the bone scan from Memorial Hospital was entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The transcript of the deposition of Dr. Frank Petkovich taken on June 30, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Petkovich testified that he is board-certified by the American Board of Orthopedic Surgery and is also certified by the American Board of Independent Medical Examiners. He testified that he stopped doing spine surgery 4-5 years ago due to an eye condition, but that he is a founding member of the North American Spine Society and still remains active in that Society. (RX1).

Dr. Petkovich testified that he examined Petitioner on October 25, 2012 and that the report was dated October 29, 212. He testified that he was also asked to review a bone scan and additional medical records from Dr. Thom and that he authored a report dated April 9, 2016 related to that review. He also testified that he reviewed MRI films dated September 27, 2012 and November 27, 2013 and that he authored a report dated May 2, 2016 related to such a review. (RX1).

Dr. Petkovich testified that it was his opinion that Petitioner sustained a muscular thoracic strain as a result of the incident she described while working on November 14, 2011. He testified that as of the examination, it was his opinion that Petitioner had reached maximum medical improvement from that diagnosis. He testified that it was his opinion that Petitioner could work without any restrictions with regard to the incident that she described occurring while at work on November 14, 2011. (RX1).

Dr. Petkovich testified that the bone scan was ordered by a physician in December of 2011 because Petitioner was having some foot pain. It was noted that Petitioner had a history of a foot surgery earlier in 2011 and then the bone scan was ordered in December of 2011 by Dr. Ravi because of the foot issue. He testified that the bone scan was not ordered to study the thoracic spine. He testified that he reviewed the films himself and that it showed increased metabolic activity in the areas of the thoracic spine because of degenerative arthritis and degenerative disc disease. He testified that there was no way to tell from a bone scan whether someone had herniated or bulging discs. (RX1).

Dr. Petkovich testified that it was his understanding that Petitioner had MRIs taken after she suffered an automobile accident in late 2012. He testified that the MRIs showed degenerative disc changes or degenerative disc protrusions but that he would not classify those protrusions as showing what he

considered to be true herniated discs. He testified that the findings on the MRIs were consistent with anyone that had degenerative disc changes in their thoracic spine and that there was nothing surgically necessary. He testified that his review of the bone scan and MRIs supported his opinions regarding medical causation and diagnosis. (RX1).

On cross examination, Dr. Petkovich testified that a bone scan for some acute injuries could be helpful with other things but there would be a lot different activity than what was on the bone scan at issue for Petitioner. He testified that Petitioner's bone scan showed some mild turnover consistent to degenerative changes and that if there were any kind of a significant bony acute process, it would be totally different. (RX1).

On cross examination, Dr. Petkovich agreed that at the time that he examined Petitioner on October 25, 2012, he had not at that time seen the bone scan. He testified that he had reviewed the radiology report for the bone scan, however, and that the reading radiologist did not even mention the spine and that the uptake was so minimal it was not even mentioned. He testified that it was his opinion that Petitioner sustained a muscular thoracic strain as a result of the November 2011 incident that it should have resolved within approximately six weeks from that incident. He testified that he did not believe that Petitioner sustained any bony injury to her spine and that he did not believe that she sustained any discogenic injury to her spine. (RX1).

On cross examination, Dr. Petkovich agreed that posture, carriage and overall physical activity had an effect on degenerative bone disease over time. He testified that if someone had an acute muscular strain, it could affect someone's ability to move around and carry themselves. He testified that if someone had a soft tissue injury and had some muscle spasm, it could alter their activity for a period of time and maybe alter the way they carried themselves for a period of time, and that it depended on the area involved. (RX1).

The medical records from Mineral Area Regional Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records reflect that Petitioner was seen on August 25, 2012 after having been brought by ambulance from the scene of an accident in which her car struck a deer that ran into the road. It was noted that Petitioner was positive for extremity pain, joint pain, myalgias and neck pain. It was noted that a CT of the brain was interpreted as "negative" with noted minimal paranasal sinusitis and that a CT of the cervical spine was interpreted as revealing normal alignment of the cervical spine with no evidence of fracture. The clinical impression was noted to be that of (1) motor vehicle accident; (2) acute traumatic cervical strain; (3) acute traumatic thoracic strain. Petitioner was discharged home and given prescriptions for medications. (RX2).

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on November 14, 2011, Petitioner sustained an accident that arose out of and in the course of her employment with Respondent. (AX1).

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being in the thoracic spine is causally related to the accident of November 14, 2011.

The Arbitrator notes that Petitioner testified that she felt the immediate onset of pain after lifting the bottle of disinfectant on the date of the accident at issue and that Respondent did not offer any evidence to contradict that this incident occurred. The Arbitrator further notes, however, that Petitioner did not offer any evidence of medical treatment or evaluation until after her motor vehicle accident of August 25, 2012 after which she was diagnosed with a thoracic sprain, which is the very same condition for which she now seeks recovery. Both Drs. Shenouda and Thom offered testimony in support of Petitioner's claim, but it is

apparent to the Arbitrator that neither of them had a clear understanding of the weight of the bottle of disinfectant and that they both were simply accepting Petitioner's complaints and history with no other corroboration.

The Arbitrator finds, on the other hand, that Dr. Petkovich took a thorough history from Petitioner and notes that he recorded far more specific information about the incident at issue than did either Dr. Shenouda or Dr. Thom and, as such, the Arbitrator find the opinions of Dr. Petkovich to be more persuasive. Petitioner at the time of arbitration could not offer any explanation as to why she did not seek medical treatment immediately, or even for several months, following the accident and that said that the provider would ask her for a "claim number." The Arbitrator finds, however, the fact that Petitioner continued to work for some nine months after the incident is suggestive of the accuracy of the very foundation upon which Dr. Petkovich's opinions are based. Accordingly, the Arbitrator agrees with and adopts the findings of Dr. Petkovich that Petitioner sustained only a muscular thoracic strain as a result of the November 14, 2011 incident at issue, and further finds that Petitioner reached maximum medical improvement as a result of the incident within six weeks, which would be December 25, 2011 at the outset of such timeframe.

With respect to issue (J) pertaining to medical services, the Arbitrator notes that no medical bills were entered into the time of arbitration. As such, no award of reasonable and related medical expenses for treatment rendered up to December 25, 2011 is able to be made under the circumstances.

With respect to issue (K) pertaining to temporary total disability benefits, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits as her own testimony established that she continued to work for Respondent for some nine months post-accident. The Arbitrator further notes that no work slips were entered into evidence at the time of evidence establishing that Petitioner was taken off work for her injuries as a result of the muscular thoracic strain diagnosed by Dr. Petkovich, who opined that Petitioner could work without any restrictions with regard to the incident that described occurring while at work on November 14, 2011. (RX1). As such, Petitioner's request for temporary total disability benefits is hereby denied.

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

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was submitted by either party. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that she was not currently employed and that her last place of employment was that of Respondent, where she worked until 2011. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 47 years old on the date of the accident at issue. Dr. Petkovich opined that Petitioner sustained a muscular thoracic strain as a result of the November 14, 2011 incident at work for which he placed her at maximum medical improvement within six weeks thereof, and that he opined that Petitioner could work with no work restrictions. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that following her work injury, Petitioner testified that she returned to her pre-accident employment with Respondent for some nine

months before she terminated her employment. The Arbitrator places little weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner offered no testimony at the time of arbitration substantiating any current complaints of pain in the thoracic spine. As a result thereof, the Arbitrator places no weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 0% loss of use of the person-as-a-whole as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Candace Haley,
Petitioner,
vs.

NO: 16WC 12003
18IWCC0454

Memorial Hospital,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of 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 December 21, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 20 2018
071618
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HALEY, CANDACE
Employee/Petitioner

Case# **16WC012003**

16WC016902

MEMORIAL HOSPITAL
Employer/Respondent

18IWCC0454

On 12/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.48% 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:

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

1679 MATHIS MARIFIAN & RICHTER LTD
DEANNA L LITZENBURG
23 PUBLIC SQ SUITE 300
BELLEVILLE, IL 62222

18IWCC0454

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

CANDACE HALEY
Employee/Petitioner

v.

MEMORIAL HOSPITAL
Employer/Respondent

Case # **16** WC **12003**

Consolidated cases: **16 WC 16092**

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

DISPUTED ISSUES

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

18IWCC0454

FINDINGS

On **November 22, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,189.61**; the average weekly wage was **$460.01**.

On the date of accident, Petitioner was **26** years of age, *single* with **1** dependent children.

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

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

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

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being is not causally related to the accident at work on November 22, 2015. Petitioner reached maximum medical improvement on April 5, 2016. Petitioner's cervical condition and treatment are not causally related.

Respondent is not liable for medical treatment after April 6, 2016.

Respondent shall pay Petitioner the sum of **$276.01 per week** for a further period of **15 weeks**, as provided in **Section 8(d)** of the Act, because the injuries sustained caused a **3% 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

December 20, 2017
Date

DEC 21 2017

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

18IWCC0454

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CANDACE HALEY
Employee/Petitioner

v.

Case #: 16 WC 12003
Consolidated with
16 WC 16092

MEMORIAL HOSPITAL
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that Petitioner sustained two separate accidents which arose out of and in the course of her employment with Respondent. The first accident occurred on November 22, 2015, (16 WC 12003) when Petitioner was transferring a patient to a slide board and the patient fell back. She testified she injured her back at that time. She completed an accident report and wrote "back" as the body part injured. On the diagram, she marked the injured body part as the middle of her back on the right. The report is undated. RX2. The second accident occurred on April 23, 2016, (16 WC 16092) when Petitioner was walking a patient to the restroom and the patient fell back, pulling Petitioner down with her. She testified she injured her entire back, from the top of her neck to the bottom of her back. She completed an accident report that day and wrote "back" as the body part injured. On the diagram, she marked the injured body part as her entire back. RX3. The issues in dispute at trial were causal connection, medical treatment following the IME of April 5, 2016, and nature and extent of the injury.

At the time of both accidents, Petitioner was 26 years old, single, and had one dependent child. She was employed by Respondent as a Patient Care Tech/CNA and had been so employed for about two years. She testified that after the first accident she worked light duty for a period of time, which Respondent accommodated, and she then returned to full duty after the IME on April 5, 2016. Petitioner testified she treated with Respondent's facility following the first accident, and treated with Dr. Gornet following the second accident.

Petitioner testified that she currently experiences a "pins and needles sensation" in the top part of her back and discomfort when walking or sitting for prolonged periods of time and when lifting and/or performing strenuous activities. She testified that these symptoms negatively impact her ability to lift, move, and assist patients at work, and her ability to play with her

daughter. She takes Meloxicam and Flexeril, prescribed and dispensed by Dr. Gornet, as well as Tylenol or Aleve on a daily basis. She testified she depends on medication to tolerate her symptoms during her clinicals as an LPN student.

On cross-examination, Petitioner admitted she has been working full duty since April 5, 2016, and that no doctor has restricted her ability to lift. She testified she is able to lift the 50 pounds required as a Patient Care Tech. She acknowledged that she voluntarily changed her employment status from full time to part time, and then to per diem, so she could attend school.

Petitioner admitted that she never experienced neck pain, and testified that she felt pain in the top part of her shoulders, which she demonstrated at hearing to be the area around the shoulder blades. She testified that she occasionally experiences a shooting pain down her right arm; however, she could not recall which doctor she had reported right arm pain to. She testified that when she saw Dr. deGrange on April 5, 2016, she had pain throughout her back. She acknowledged that this was approximately five months after the first accident. She testified that she started feeling pain in the top part of her back after the second accident on April 23, 2016. Petitioner agreed that all the physical therapy she received was for her low back. She conceded that Dr. Gornet was the first physician to treat her cervical spine. Petitioner testified that the two injections she received did not affect her low back pain at all. She confirmed that Dr. Gornet had not recommended any treatment for her low back.

Following the first accident, Petitioner reported to Employee Health Services at Memorial Hospital on November 24, 2015, and was seen by Physician's Assistant Andrew Colon. She gave a consistent history of the accident and complained of right-sided low back pain which she rated at 6/10. She denied radicular pain to the upper or lower extremities. She was advised to take anti-inflammatories and apply warm compresses, and she was placed on restrictions of no lifting, pushing, or pulling more than five pounds. On December 1, 2015, she returned to Health Services and reported continued low back pain which was worse when she laid down. She advised warm compresses did not help and she was not taking over the counter pain medication because she "can't swallow pills". She complained of right flank pain but no radicular pain. She was tender to palpation. She was continued on restricted work duties and referred to physical therapy. Diagnosis was "right lower trap, right latissimi dorsa". PX3, RX4.

On December 10, 2015, Petitioner presented to Memorial Rehabilitation Services for therapy. She completed a history intake form and wrote "back pain" for her main complaint. She marked on the diagram that the pain was in the right mid-back area. The therapist noted Petitioner's thoracolumbar range of motion was normal, with end range stiffness into bilateral side bending. Manual muscle testing was deferred due to high reactivity to pain. There was marked point tenderness in the thoracolumbar paraspinals on the right, and voluntary and involuntary muscle guarding. Petitioner returned to therapy on December 14. Complaints and examination findings were the same. PX3, RX4.

Petitioner returned to Employee Health Services on December 15, 2015, and reported middle to right-sided low back pain. She was not taking any medications and was using a heating pad at home. On examination, there was tenderness to palpation across the low back, more to the right side. She had good heel/toe strength and range of motion was limited. She was

instructed to continue work restrictions and physical therapy, and to take over the counter medicines. PX3, RX4.

Physical therapy records note Petitioner did not keep her appointment on December 16. She returned on December 17 with continued complaints and noted, "My spine at my waist area feels like it needs to pop." Therapy records note Petitioner did not keep her appointment on December 18. PX3, RX4.

On December 22, 2015, Petitioner returned to Employee Health Services and was wearing a back brace she had purchased. She reported "It helps, like a corset. It makes it feel better." She was advised to discuss use of the brace with her physical therapist. She continued to complain of pain in her right to middle low back and advised she occasionally had spasms. She again reported she was not taking any over the counter medication. On examination, there was some tenderness to palpation in the lumbar area. She was instructed to continue work restrictions and physical therapy, and to take over the counter medications. Petitioner attended physical therapy on December 23 and 24. PX3, RX4.

On December 28, 2015, Petitioner presented to the emergency room at Memorial Hospital. She noted her accident the prior month and advised she continued to have "achy throbbing low back pain". She reported that physical therapy was helping a bit. On examination, the lumbar paraspinous muscles were tender to palpation but range of motion was not limited. The Arbitrator notes that exam of the neck was normal. Petitioner was given an injection in the ER and was prescribed Tramadol, Cyclobenzaprine, and Ibuprofen. She was advised to apply hot compresses to the lower back for symptomatic relief and to follow up with her physician. PX3, RX4.

On December 29, 2015, Petitioner followed up with Employee Health Services and advised she went to the emergency room "because pain worsened to throbbing from lower back up spine between shoulders". She stated that "while undergoing PT yesterday she felt sharp pain ascend into her upper back". The Arbitrator notes, however, that the neither the records nor the bills show that Petitioner attended physical therapy the day before. On examination, Petitioner "exhibited pain to very light touch along left and right scapular blades", but no pain when distracted. Continued physical therapy was ordered, with the addition of instructions to "include Waddell's evaluation". On January 4, 2016, Petitioner called Employee Health Services and advised she was having worse back pain because she was required to walk a patient to MRI and back again, and that she was "supposed to be on sedentary duties". PX3, RX4.

On January 6, 2016, Petitioner attended physical therapy and reported that her back pain was still limiting her ability to walk for more than five minutes at a time. She rated her pain at 6/10. She also reported that the medications were working and that she had less pain when she sat. That same day Petitioner called Employee Health Services and advised she was not working within her means/restrictions. She stated she was in the Modified Program and was to be on sedentary duty. A call was made by "S. Todlock", presumably a nurse, to Cynthia Wolfe in the nursing office, who confirmed that Petitioner was assigned to assist with a patient and to take the patient's vital signs, and that she was working within her restrictions. Ms. Todlock discussed the issue with Dr. Byler on January 7, who advised that taking vital signs was within Petitioner's

current restrictions. That information was passed along to Petitioner. Later that day, Petitioner attended physical therapy. It was noted she continued to complain of low back pain which was resolving intermittently with or without treatment. It was further noted that her objective findings had not changed since her initial assessment on December 10, 2015. PX3, RX4.

On January 8, 2016, Employee Health Services received a call from "G. Riley, RN manager", who advised that Petitioner complained of back pain to the staff and stated that she could do nothing but sit. Further, Petitioner "had her iPad and phone in her bed in patient's room". A call was made to Petitioner, to remind her of Dr. Byler's decision regarding her sedentary work status and that it was ok for her to do vitals on a patient, feed a patient, and get their water. It was noted Petitioner became defensive, stating, "No one is on my side. They stopped my PT because the pain is worsening." When asked when her last PT visit was "she was vague". She reported she was going to see her primary care physician that week but when asked who she was seeing she did not provide the name. A return appointment with Health Services was scheduled for January 11, 2016. PX3, RX4.

On January 11, 2016, Petitioner returned to Employee Health Services. She reported that her last therapy visit was January 7 and that "it wasn't doing anything" for her. She advised she had been working on sedentary duty but continued to have pain in her mid to lower back. She denied radiation to the legs or buttocks. On examination, there was pain to direct palpation at T4-5 but no pain along the scapular border. A thoracic MRI was ordered, which was completed on January 13, 2016. It revealed mild degenerative disc desiccation and minimal disc bulging at T7-8, but otherwise was normal. PX3, RX4.

Petitioner was scheduled to return to Health Services on January 18, but records note she was a "no show, no call". She did return on January 19, 2016 and advised she was working sedentary duty and that she could not go to her primary physician because of insurance. She reported that her mid to lower back still hurt and that the pain never went away. She advised she had constant central mid back pain that radiated to the right lower thoracic and upper lumbar areas, that muscle relaxers helped but physical therapy did not. It was recommended that she continue on restricted duty and be evaluated by an IME/physiatrist. PX3, RX4.

The next medical record is from March 30, 2016, when Petitioner called Employee Health Services. She complained of pain in her middle and lower back, as well as in her left shoulder. She advised it was shooting pain, up and down the back. She was out of muscle relaxants and pain medication and was not sure where she received the medications. It was noted that EHS records were reviewed and that no prescriptions had been given by their facility. Petitioner stated her pain was much worse and that she was unable to care for her daughter. She was instructed to use over the counter anti-inflammatories and warm compresses, and she was referred to Human Resources for additional assistance. PX3, RX4.

On April 5, 2016, Petitioner was evaluated by Dr. Donald deGrange, Respondent's Section 12 examiner. She completed a medical history form and noted that 75-100% of her pain was in her back and 18-20% was in her arms. She indicated that sitting for extremely long periods made the pain worse, as did walking and lifting. She further indicated that when she had pain in her shoulder blades it felt as though she had a sharp rushing pain down her arm and

shoulder. On the pain diagram, she marked pain in both shoulder blades, center mid back, and low back to the right. RX2, Dep. RX2.

Petitioner gave a consistent history of the accident and her treatment to date. She reported she had been on light duty from the date of accident "until approximately two weeks ago and has not worked since that time". She stated her symptoms were currently worse than when the accident occurred five months prior. She reported her chief complaint was diffuse back pain that began in the lumbosacral area and radiated up into the mid and upper back and into the shoulders. She also reported numbness throughout the back and into the shoulders, as well as headaches. She reported the symptoms were worse at the bottom of her spine and went into the right buttock area. Dr. deGrange specifically noted, "Although the pain, which begins in the low back, shoots up to her shoulder blades, she is denying any neck pain; nor is there any numbness or tingling in her feet or toes." RX2, Dep.RX3.

On examination, it was noted Petitioner had no abnormal components to her gait and had no difficulty arising from the seated position. There was diffuse tenderness with allodynia from T1 through the sacrum, but no palpable or detectable muscle spasms. Range of motion was decreased in forward flexion and extension. Dr. deGrange noted there was mild but noticeable give-way weakness of knee flexion/extension, ankle plantar flexion, and dorsiflexion. There were no sensory deficits and deep tendon reflexes were normal. RX2, Dep.RX3.

Dr. deGrange reviewed medical records from Memorial Hospital, Employee Health Services, and Memorial Rehabilitation Services. After reviewing the records, obtaining a history from Petitioner, and performing a physical examination, Dr. deGrange diagnosed Petitioner with thoracic and lumbar strains. He opined that the injuries would normally have resolved within four to six weeks, and he therefore placed her at maximum medical improvement on approximately January 7, 2016. He found no objective basis, either on physical examination or the MRI, in support of Petitioner's subjective complaints. He further noted that there were several nonphysiologic findings on exam which were not consistent with the claimed injury. He further noted that although the MRI showed mild findings at T7-8, those findings did not correspond with Petitioner's presentation. He opined "In light of the significant discrepancy between the subjective complaints and objective findings on examination and diagnostic studies, I will have to conclude based upon this evaluation that there is symptom magnification at this point in time." RX2, Dep.RX3.

On Saturday April 23, 2016, Petitioner reported her second work accident (16 WC 16092), when she was walking a patient to the restroom and the patient fell back, pulling Petitioner down with her. On Monday April 25 at 3:10 p.m. Employee Health Services noted a call from "M. Wuller", stating Petitioner had been injured on April 23 and had arrived to work and complained of pain and wanted to be seen. Nurse Todlock advised there was no provider available until the next day, and an appointment was made. Petitioner asked what other options she had and was instructed she could be seen in the emergency room if warranted. PX3, RX4.

On April 25, 2016, at 4:50 p.m. Petitioner presented to the emergency room at Memorial Hospital. She reported she was helping a patient stand from the toilet with a gait belt when the patient fell back, causing Petitioner to have back pain. Examination of the neck was normal.

Examination of the back revealed muscle spasm from the mid back up to the shoulder blades. There was no numbness, tingling, or weakness. Thoracic x-rays were normal and cervical x-rays showed multilevel degenerative changes. Petitioner was prescribed pain medication and instructed to follow up with her primary care doctor in a few days if not better. PX3, RX4.

Petitioner presented to Employee Health Services on April 26, 2016, and reported burning pain across the top of her back. She stated that her back was "never better from the last time" and that she had back pain every day. She noted that Dr. deGrange had released her back to full duty and she returned to full duty on April 17, but that she had not been lifting. Following the incident on April 23, she felt like she had "a blow torch" to her back and had spasms. She reported that the medications from the ER did not help and that she had "her own doctor's appointment that her lawyer set up". The record notes that Petitioner stood during the interview with medical personnel for about 15 minutes. On examination, she was very tender to very light touch across her upper, mid, and lower back. There was no specific point tenderness, but rather more general tenderness. She refused to attempt range of motion movements due to pain. It was noted that, based on Petitioner's previous IME, her current history, and her physical examination, she was released to regular duty effective immediately. The record notes that Petitioner became upset, shouted at staff, and "flung open" the door hard enough to bang the wall. PX3, RX4. The Arbitrator notes this is the final record from Employee Health Services and Memorial Hospital.

On May 5, 2016, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis. Her main complaint was upper back pain to both shoulders and pain between her shoulder blades. She also had some low back pain to the right side. She reported her work accident of November 22, 2015, and gave a consistent history of its occurrence. The Arbitrator notes, however, that she did not mention her work accident of April 23, 2016. Petitioner advised Dr. Gornet that she had returned to full duty work two weeks prior, but continued to have pain. Her symptoms were constant and worse with bending, lifting, or prolonged sitting, and better with change in position. She denied significant arm pain or numbness. PX4.

On examination, there was pain in the upper back, almost to the trapezius, but more upper back and between her shoulder blades. She had a mild decrease in biceps strength on the right. Other findings were normal. Dr. Gornet's assessment was potential referred mid-back pain and low back pain, which he opined was causally related to Petitioner's accident of November 22, 2015. He noted that while her pain was in her mid-back, the scapular area was often a referred area from the cervical spine. With the right biceps weakness also present, he recommended a cervical MRI to further evaluate. He opined that Petitioner's complaints were consistent with an aggravation of her thoracic disc degeneration. He recommended Petitioner continue working full duty and noted consideration would be given to thoracic injections. PX4.

Petitioner underwent the cervical MRI the same day, which revealed (1) C4-5 central herniation possibly with annular fissure but without significant foraminal component; and (2) C5-6 small central herniation. PX5.

Dr. Gornet reviewed the MRI and noted the herniations were consistent with Petitioner's structural neck pain and upper back pain. He recommended steroid injections at C4-5 and C5-6

and referred Petitioner for same. He also dispensed Meloxicam and Cyclobenzaprine from his office. He again opined that the injuries were related to Petitioner's work accident. PX4.

On May 16, 2016, Petitioner spoke with Dr. Gornet by phone and advised the medication was "helping her knee pain" but was not helping her neck. Dr. Gornet advised her to continue the Meloxicam and a different muscle relaxer would be called in. PX4.

On May 31, 2016, Petitioner underwent left C4-5 and C5-6 epidural steroid injections by Dr. Helen Blake, upon referral by Dr. Gornet. On June 14, 2016, she underwent an additional injection at C5-6. PX6.

On June 1, 2016, Dr. deGrange authored a supplemental IME report, upon receipt of the cervical MRI obtained by Dr. Gornet. He noted that at the time of Petitioner's examination on April 5, 2016, she had no complaints of any neck pain. Rather, she had diffuse pain from the top of the thoracic area through the lumbosacral region. He also reviewed the treating medical records previously provided and reviewed, and noted that none of those records contained any complaint by Petitioner of neck pain. He reviewed the cervical MRI of May 5, 2016, and noted that the radiologist found central herniations at C4-5 and C5-6. Dr. deGrange noted, however,

> *"I have reviewed this same MRI, and I find small bulges of no clinical significance also at C4-5 and C5-6. Owing to the absence of any cervical symptoms or findings, any upper extremity symptoms or findings, these would be incidental findings at best without any clinical correlation. Furthermore, the patient was evaluated on multiple occasions by multiple providers, none of whom found or documented these new complaints. I am therefore of the opinion that these new findings are not medically causally related to the incident in question. Furthermore, the initial encounters shortly after the incident, as opposed to six months removed, are in most cases the most accurate depiction of the reality or truth."* RX1, Dep.RX4.

Dr. deGrange testified by way of deposition on June 14, 2016. He is a Board Certified Orthopedic Surgeon, fellowship trained, who specializes in spinal surgery. He testified consistent with his reports. RX1.

Dr. deGrange testified that Petitioner completed a symptom diagram at the time of the examination and indicated diffuse axial pain somewhere from about the mid thoracic through the lower thoracic area, all the way down to the lumbosacral junction. She provided a history of injuring herself on November 22, 2015, resulting in the onset of low back pain and what she described as mid back pain. At the time of her examination, Petitioner's chief complaint was diffuse back pain from the mid thoracic area to the thoracolumbar area and the lumbar area all the way down to her hips and sacrum. She also described numbness throughout the back and into the shoulders, as well as headaches. She reported that her symptoms were worse at the bottom of her spine and into the right buttock area. She also reported that her symptoms were actually worse on the date of the IME than previously. RX1.

Dr. deGrange testified that Petitioner's symptoms were diffuse and poorly localized. She denied radicular symptoms radiating into the legs or feet. On examination, she did not have any significant spasm. She was able to get out of the chair in the exam room without any problems.

Dr. deGrange observed give-way weakness, which he testified was not true weakness, but rather a non-physiological finding. Dr. deGrange testified that he did not find any objective findings to support Petitioner's subjective complaints and that she exhibited an exaggerated response to light touch. He further testified that he observed elements of symptom magnification, such as allodynia (exaggerated response to light touch), give-way weakness, and nonorganic findings on simulated axial compression testing. Dr. deGrange testified that Petitioner had reached maximum medical improvement as of January 7, 2016, and that she could work full duty. RX1.

Dr. deGrange testified that subsequent to his examination of Petitioner he was provided with Dr. Gornet's office note and the cervical MRI of May 5, 2016. He testified consistent with the contents of his supplemental report. RX1.

Dr. deGrange testified that scapular pain on one side can be referred pain from a cervical problem. However, he explained that this scapular pain has to be fairly specific in its location, as opposed to Petitioner's symptoms which were quite diffuse and non-anatomic in location. Further, he testified that there has to be some component of neck pain and that Petitioner made no complaints to him of neck pain and did not indicate any neck complaints on the symptom diagram. He testified that none of his previous opinions changed based upon his review of Dr. Gornet's office note and the cervical MRI. He opined that the medical treatment recommended by Dr. Gornet for the cervical spine was not causally related to Petitioner's work injury. RX1.

On cross-examination, Dr. deGrange was asked about an order for physical therapy for the right lower trapezius and right latissimus dorsi that was written by Employee Health Services on December 10, 2015. He explained that both the trapezius and latissimus muscles are very large muscles and they cover a great swath of the back. He further testified that both muscles take their origin from the mid to lower back, and noted that the physical therapy orders referred to the "lower" trapezius. Dr. deGrange testified that he was unaware of the occurrence of Petitioner's second accident on April 23, 2016. RX1.

On August 1, 2016, Petitioner followed up with Dr. Gornet and reported that the injections she had received gave only temporary relief. Dr. Gornet recommended observation only and opined that Petitioner was not yet at maximum medical improvement. He noted that "her only surgical option" would be disc replacement surgery at C4-5 and C5-6. He recommended she continue working full duty and he dispensed Meloxicam and Cyclobenzaprine from his office. Petitioner was to follow up in two months. PX4.

Petitioner did not return to Dr. Gornet until January 30, 2017, five months later, at which time she reported she continued to have "significant neck pain, upper back into both shoulders, pain between her shoulder blades". She was continuing to work full duty. Dr. Gornet noted they talked about disc replacement surgery and he believed she would probably require surgical intervention; however, Petitioner was fearful. Dr. Gornet opined that her best option was to try and live with her symptoms, "with the understanding she will probably require this treatment in the future". He placed Petitioner at maximum medical improvement and released her from care. PX4. The Arbitrator notes this is the final treatment record. PX4.

Dr. Gornet testified by way of deposition on September 12, 2016. He is a Board Certified Orthopedic Surgeon, whose practice is devoted exclusively to the care and treatment of the spine. He testified consistent with his treating records. PX7.

Dr. Gornet testified that a portion of the midback pain that Petitioner was complaining of was often a pain that can be referred from the cervical spine. He noted that the cervical MRI revealed central disc herniations at C4-5 and C5-6, but they were not causing any significant cord compression. He provided images of the MRI views that best illustrated the pathology responsible for Petitioner's symptoms. PX8. Dr. Gornet testified that the herniations accounted for Petitioner's axial midback pain, pain in her trapezius and between her shoulder blades, and the portion of the pain at the base of her neck. He diagnosed Petitioner with a disc injury in the cervical spine, and testified that she does not have severe neurological dysfunction or impairment. He recommended only conservative care consisting of injections, anti-inflammatories, and muscle relaxants. He opined that Petitioner's current symptoms and need for treatment were directly related to her accident on November 22, 2015. PX7.

On cross-examination, Dr. Gornet acknowledged that as of the time of his deposition he had seen Petitioner on only two occasions. He testified that her main complaint was upper back pain, really to both shoulders, with pain between her shoulder blades. She also had a component of low back pain to the right side. He testified that Petitioner related to him that this main complaint of upper back pain began on about November 22, 2015, when she was injured. He admitted that when he first saw Petitioner on May 5, 2016, she denied significant arm pain or significant numbness. He acknowledged that on physical examination that day her sensation and strength were normal. He admitted that Petitioner did not complain of neck pain and did not mention neck pain on her pain diagram. He acknowledged that the plain x-rays showed spurring at C4-5, which was a degenerative finding. He conceded that he had not worked up Petitioner's low back. Dr. Gornet confirmed that he had maintained Petitioner on full duty work status since his initial visit on May 5, 2016. PX7.

Attached to the transcript of Dr. Gornet's deposition was a Medical Information form and Patient Pain Drawing, completed by Petitioner. The Arbitrator notes that Petitioner included only the accident date of November 22, 2015, and she made no mention of an accident on April 23, 2016. On the pain diagram, there was no indication of neck pain or pain at the base of the neck. PX7, Dep. RX2.

CONCLUSIONS OF LAW

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

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

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

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to her work accident of November 22, 2015, or her work accident of April 23, 2016. In addition, the Arbitrator specifically finds that Petitioner's cervical condition and treatment are not causally related to either accident.

Following the first accident of November 22, 2015, Petitioner complained of only right low back pain. This is confirmed by the medical records and the accident form which Petitioner completed. The records reveal that her complaints extended into the mid back area, primarily on the right side. At the time of the IME on April 5, 2016, which was prior to the second accident date, Petitioner complained of diffuse back pain. She marked on the symptom diagram that she was having pain in her shoulder blades, center mid back, and low back to the right. She made no markings on her neck, and assigned no percentage of her pain to her neck. Further, and most telling, Petitioner admitted at trial that she has never experienced neck pain. She testified that she injured her upper back during a second accident on April 23, 2016, yet as detailed above, she was already complaining of upper back pain when she saw Dr. deGrange on April 5, 2016.

With regard to the accident of April 23, 2016, the Arbitrator finds it compelling that Petitioner made no mention to Dr. Gornet whatsoever of this incident when she saw him for the first time on May 5, 2016, nor at any time thereafter. Dr. Gornet's causation opinion is based on an incorrect history. Petitioner reported to him that her main complaint was upper back pain, primarily pain to both her shoulders. She further reported to him that all of her symptoms, including this main complaint, started after the first accident of November 22, 2015. This is inconsistent with the accident report that she completed and the medical records. Dr. Gornet causally related all of Petitioner's complaints, including the upper back pain, to the accident of November 22, 2105. Petitioner did not mention the second accident date, and Dr. Gornet's records and deposition testimony are void of any mention of a second accident. Dr. Gornet did not causally relate any of his treatment to a second accident.

At the time of the IME with Dr. deGrange on April 5, 2016, Petitioner complained of diffuse back pain. This was 18 days before the second date of accident and five months after the first accident. This was the first time Petitioner made such broad complaints, as all of her prior complaints were to the mid and low back. Dr. deGrange testified that there were no objective findings to support Petitioner's subjective complaints and he noted signs of symptom magnification, which he documented in detail. He testified that Petitioner's complaints were poorly localized and non-anatomic in location. Petitioner's complaints to Dr. deGrange were inconsistent with those documented after the accident on November 22, 2016. Dr. deGrange testified that the treatment to Petitioner's cervical spine as recommended by Dr. Gornet was not causally related to the work accident. The Arbitrator agrees.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to meet her burden of proof on the issue of causal connection with regard to her cervical spine. The Arbitrator finds that Petitioner reached maximum medical improvement for the first accident on April 5, 2016, that being the date of Dr. deGrange's examination. Although the parties stipulated that a second accident occurred on April 23, 2016, the Arbitrator finds this accident was of no consequence and did not injure Petitioner in any significant manner. Petitioner obviously did not believe this was a significant incident either, as she did not mention it to Dr. Gornet when she saw him for the first time less than two weeks later. The Arbitrator finds that Petitioner reached maximum medical improvement for the second accident on April 26, 2016, that being the date she saw Employee Health Services.

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

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

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered through April 5, 2016, were reasonable and necessary in Petitioner's care and treatment relative to her accident of November 22, 2015. In addition, the Arbitrator finds that medical services rendered April 25 and April 26, 2016, were reasonable and necessary in Petitioner's care and treatment relative to her accident of April 23, 2016.

The parties stipulated that Respondent has paid for all medical services except those rendered by or at the direction of Dr. Gornet, beginning May 5, 2016. In light of the Arbitrator's findings above, Respondent is not liable for these additional medical bills.

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

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

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

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Patient Care Tech at the time of both accidents and was able to

return to work in that same capacity without any restrictions or limitations as a result of either accident. Petitioner testified she is currently working on a per diem basis at her request, while she attends school to become an LPN. The Arbitrator gives significant weight to the fact that Petitioner returned to work without restrictions and gives significant weight this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 26 years old at the time of both accidents. She was able to return to her prior position without limitation. Over time her condition could improve, stay the same, or get worse. There was no evidence to indicate with any degree of likelihood how her age would impact her disability, and the Arbitrator declines to speculate as to same. The Arbitrator gives some weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner returned to her prior position full duty and worked in that capacity until she requested to go to part time and then per diem status so she could attend school. The Arbitrator places no weight on this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes Petitioner sustained a thoracic and lumbar strain for which she was treated conservatively for several months. She testified she continues to have symptoms with activity and continues to take medication prescribed and dispensed by Dr. Gornet. The Arbitrator notes, however, that these complaints are related to her cervical spine, which was found above to not be causally related to either accident. The Arbitrator gives some weight to this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1 does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that as a result of her accident of November 22, 2015, Petitioner has sustained a 3% loss of use of the person as a whole (15 weeks) with respect to her thoracic and lumbar spine pursuant to Section 8(d)2 of the Act. The Arbitrator further finds that as a result of her accident of April 23, 2016, Petitioner has sustained no disability. The parties stipulated that Petitioner's average weekly wage was $460.01. The Arbitrator finds her permanent partial disability rate is $276.01.

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

Candace Haley,
Petitioner,
vs.

NO: 16WC 16092

18IWCC0455

Memorial Hospital,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of 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 December 21, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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.

JUL 20 2018

DATED:
071618
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HALEY, CANDACE
Employee/Petitioner

Case# **16WC016092**

16WC012003

MEMORIAL HOSPITAL
Employer/Respondent

18IWCC0455

On 12/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.48% 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:

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

1679 MATHIS MARIFIAN & RICHTER LTD
DEANNA L LITZENBURG
23 PUBLIC SQ SUITE 300
BELLEVILLE, IL 62222

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

CANDACE HALEY
Employee/Petitioner

v.

MEMORIAL HOSPITAL
Employer/Respondent

Case # **16** WC **16092**

Consolidated cases: **16 WC 12003**

18IWCC0455

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

DISPUTED ISSUES

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

FINDINGS

On **April 23, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,189.61**; the average weekly wage was **$460.01**.

On the date of accident, Petitioner was **26** years of age, *single* with **1** dependent children.

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

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

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

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being is not causally related to the accident at work on April 23, 2016. Petitioner reached maximum medical improvement on April 26, 2016. Petitioner's cervical condition and treatment are not causally related.

Respondent is not liable for medical treatment after April 26, 2016.

Petitioner sustained no disability as a result of this accident.

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

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

December 20, 2017
Date

DEC 21 2017

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

Lisa Anderson,

Petitioner,

vs. NO: 15WC 17453

Pekin Hospital,

18IWCC0456

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, 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 August 25, 2017, is hereby affirmed and adopted.

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

18IWCC0456

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: JUL 20 2018
o071618
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

ANDERSON, LISA
Employee/Petitioner

Case# **15WC017453**

PERKIN HOSPITAL
Employer/Respondent

18IWCC0456

On 8/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

5316 LEFANTE LAW OFFICES PC
JAMES LEFANTE
456 FULTON ST SUITE 419
PEORIA, IL 61602

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

18IWCC0456

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

- [ ] 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)

Lisa Anderson
Employee/Petitioner

v.

Pekin Hospital
Employer/Respondent

Case # 15 WC 17453

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Peoria**, on **3/20/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0456

FINDINGS

On the date of accident, **1/20/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$24,702.60**; the average weekly wage was **$475.05**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **1** dependent child.

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

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

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

ORDER

Because Petitioner failed to establish that her current condition of ill-being is causally related to the accident, benefits are denied.

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

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

Michael K. Nowak, Arbitrator

7/17/17
Date

ICArbDec19(b)

AUG 25 2017

18IWCC0456

FINDINGS OF FACT

Petitioner was employed as a full time cook by Pekin Hospital. Her job duties as cook required her to make sure her production sheets were completed, perform food preparation, ensure appropriate preparation and cooking of all foods, and do the general duties of a cook. Petitioner's shift at Pekin Hospital was from 5:30 a.m. to 2:30 p.m. At the time of the incident at issue, Petitioner was also employed by TGI Friday Restaurant as a part time waitress working approximately 20 hours a week.

On January 20, 2015 Petitioner was working in the Pekin Hospital kitchen when she slipped in bacon grease and suddenly fell backwards landing on her back. She testified that she was initially primarily concerned with her knee because she had previously had surgery on it several years earlier. Petitioner was helped up by one of two supervisors who came over to assist after the fall. She testified she felt stabbing back pain following the fall.

The statement of three witnesses who were either supervisors or co-workers of Petitioner. The parties stipulated that none of these witnesses observed the fall itself. Petitioner testified that one of her supervisors who were on the scene stated "we might need to fill out an accident report," but no one provided her with an incident report to fill out. She denied that she refused to fill out an incident report. Petitioner further testified that both of her supervisors asked if she was "ok" and that she responded she didn't know. Petitioner made no complaint of back pain or injury to her supervisors at that time.

The statement of LeAnn Marshfield indicates that Petitioner did not want to fill out any type of accident report. The statement further establishes Petitioner stated that she hoped that she did not blow out her knee. She indicated that Petitioner was asked whether she wanted to fill out an accident report and Petitioner denied the offer.

The statement of Theresa Payne noted Petitioner fell onto her knee and indicated to Ms. Payne that she would be alright. Ms. Payne was at the accident scene immediately following the accident. Ms. Payne's statement indicates that Petitioner was offered the opportunity to fill out an accident report and Petitioner said she was okay and did not want to fill out the report.

The statement of Susette Litwiller notes that Petitioner did not have any low back complaints immediately following the accident. Her first noted knowledge of back complaints is April 7, 2015. (RX 7)

Petitioner testified that after she got up off the floor she went into the employee locker room to regain her composure. She took four Tylenol and returned to work finishing the shift. Petitioner testified that she did not work any additional waitressing shifts after January 20, 2015. Petitioner continued to work for the Respondent between January 21, 2015 and February 9, 2015. Petitioner did not seek medical attention during this period.

Petitioner testified that her pain increased substantially in February. Specifically, she testified that she woke up one night in extreme pain and that she could not sit or stand. In the early morning hours of February 10, 2015, Petitioner went to the Pekin Hospital Emergency Department. Petitioner testified that she was in so

much pain she could not even talk to the doctors. She indicated she could not recall if her boyfriend spoke to the doctors.

The records of Pekin Hospital from February 10, 2015 establish that Petitioner was initially evaluated by Gail Williamson, MD. (PX 8, RX 11) Dr. Williamson's history of present illness reflects:

> From what I can get from the boyfriend of the patient, for last two weeks she has been complaining of some nonspecific lower back pain. Then for over the three or four days she has been complaining of this pain has gone to her right flank, goes back toward the spine, and then goes forward into the abdomen. The pain has been there almost constantly and it was made much worse on the day of admission, she decided to come to the emergency room....She has not fallen. She has had no trauma to the chest or abdomen.

(RX 11, p.14) Dr. Williamson's examination revealed "when I palpate the spine there is no tenderness. when I percuss the spine she seems to have tenderness around the T9, T10, and T11 area." *Id.*, at 15. The assessment indicates, in part, "1. Right flank pain – with an abnormal urinalysis there is concern for pyelonephritis. I myself am concerned that this has more to do with her spine. She hurts more when I percuss the spine and seems to have more pain when she is moving around and trying to get comfortable. *Id.*

Petitioner was admitted to the hospital by Dr. Williamson for further evaluation and treatment including a urinalysis to rule out Urinary Tract Infection (UTI) and a pain management consultation from Dr. Grochowski.

A urinalysis was performed which ruled out a UTI. Lumbosacral x rays revealed thoracolumbar levoscoliosis, facet degeneration greatest at the lower two levels with grade I L4 and grade I L5 spondylolisthesis, and disc space narrowing at all lumbar levels. The impression was "degenerative changes as described." (PX 8, p. 353) Thoracic spine x rays showed thoracic dextroscoliosis, thoracolumbar levoscoliosis, degenerative changes in the spine with multilevel mild disc space narrowing, and multilevel endplate degeneration with small marginal osteophyte formation anteriorly. The impression was "scoliosis with spondylosis." *Id.* at 354. An MRI which was performed on February 13, 2015 revealed a moderate left lateral disc bulge with disc material extending into the left neural foramen at L1-2, a large left lateral disc protrusion with disc material extending into the left neural foramen with some compression of the ventral thecal sac at L4-5, mid disc bulges at all other levels, and facet joint hypertrophy at L2-3, L3-4, and L4-5. The impression was "Large left lateral disc protrusion at L4-5 as described. Less significant degenerative changes at other levels." *Id.* at 356. The history contained on the report of hip x rays taken during the admission indicate "[s]acral pain for 5 weeks. No injury." Id. at 46. Petitioner was discharged from the hospital on February 13, 2015 with a recommendation to follow up with Dr. Grochowski on February 19, 2015 and her PCP, Dr. Shepherdson. The hospital records do not mention any accident or injury. In fact, Petitioner denied any accident or trauma.

Petitioner returned to her position as a cook at Pekin Hospital and continued to perform her job. She indicated she was working with back pain.

On February 17 Petitioner followed up with Dr. Shepherdson. Dr. Shepherdson assessed low back pain and myalgia and myositis. He felt her symptoms were primarily due to lumbosacral strain. (PX 2, p. 75) There is no mention of any accident or injury.

On February 19, 2015, Petitioner presented to Dr. Grochowski. Dr. Grochowski reviewed the February 13, 2015 MRI and diagnosised a herniation at L4-L5 and right L3-S1 facet syndrome. Dr. Grochowski recommended a right L3-S1 facet injection and prescribed a Fentanyl patch for pain. Petitioner was further advised to continue taking the previously prescribed Norflex and Naproxen. Again, there is no mention of an injury or accident. (PX 8, p. 377)

On March 9, 2015, Petitioner presented to Dr. Grochowski and was given a right L3–S1 facet joint injection. *Id.* at 385

In March 2015 Respondent advised Petitioner that co-workers had observed her having difficulty performing her job duties. Respondent therefore requested that she undergo a fitness for duty examination.

Petitioner testified that she participated in the fitness for duty examination on March 20, 2015. The examination was performed at OSF St. Francis Center for Occupational Health. Petitioner was examined by Dr. David Braun, MD. Dr. Braun's report indicates that Petitioner "asked her back doctor what caused [her back pain]. He said that she likely had a fall or a lifting injury that caused this. She then told me that she believes that her back pain was caused by a slip on some grease at work in February prior to her hospitalization. When asked if she reported this to work, she said no but two supervisors helped off the ground that day and remember the event." (PX 1, p. 50) Petitioner provided a medical history indicating that "she has 'pulled her back at times in the past', but has had no formal diagnosis or treatment previously for her low back pain. She reports no injuries that she can recall to her low back except for the fall that she reported to me in February as described above." *Id.* at 51. After examining Petitioner, Dr. Braun indicated that before recommending she return to unrestricted duty he would like a note from the provider of treatment for her back pain stating that she was able to work without restrictions to be followed by a work capacity evaluation. He indicated that in the interim Petitioner could return to work with restrictions of lifting no more than 10 lbs. and rare twisting and bending at the waist. *Id.* This is the first notation in any medical record indicating that Petitioner injured her low back when she fell on January 20, 2015.

Petitioner returned to Pekin Hospital and continued to work a weekend shift on Saturday. March 21 and Sunday, March 22, 2015. She had also worked a partial shift on March 23, 2015 when she was informed by her supervisor that, based upon the results of the fitness for duty examination, she could no longer work as a cook at Pekin Hospital until she was cleared by her treating physician. Petitioner testified that she was told she had to take FMLA leave until she was released to return to work without restriction.

The statement of Theresa Payne indicates that Petitioner did not make any complaints regarding her low back until late March 2015. The statement of Susette Litwiller indicates that on April 7, 2015 Petitioner informed her that she was going to her primary care doctor for a procedure on April 13, 2015.

On March 24, 2015, Petitioner presented to Dr. Grochowski. Dr. Grochowski assessed cervical muscle spasm, lumbar spondylosis, and right L3-S1 Facet Syndrome for which he recommended a radiofrequency ablation procedure.

On April 1, 2015, Petitioner completed a Group Short-Term Disability Statement. In that statement, she indicated her disability was due to an injury, however she responded to the query "Please describe your Sickness

or how your Injury occurred" by writing "severe back pain." (RX 9) She further indicated her disability was not due to her "occupation." *Id.*

On April 2, 2015, Petitioner presented to Dr. Shepherdson to have paper work filled out for FMLA. The record related to the visit states:

> [Petitioner] states she fell at work about one month before experiencing severe disabling pain in her low back which required a brief hospitalization and subsequent treatment through pain management. She states she had been back working her normal job without problem, but then had a work note restricting her lifting to 10 pounds and was told that wasn't compatible with her job requirements, and her employer completed FMLA papers without apparent physician advice input, and she was told she needed further insurance papers completed by her PCP with a note to return to work without any restrictions, or no work would be available for her. (PX 2, p. 77)

Dr. Shepherdson expressed "considerable reservation" in determining work status and deferred that opinion to her treating pain management physician. *Id.* This was the first mention of the on the job injury contained in Dr. Shepherdson's records.

On April 13, 2015, Petitioner presented to Dr. Grochowski for radio frequency denervation of the right L3- S1 facet joints. Due to an error, the radio frequency denervation was performed on her left lumbar facet joints. On April 22, 2015, Petitioner presented to Dr. Grochowski with complaints of continued lumbar pain following the left L3-S1 radiofrequency denervation procedure. Dr. Grochowski performed a radio frequency denervation of the right L3- S1 facet joints. On April 28, 2015, Petitioner presented to Dr. Grochowski for follow up after her right L3-, L4, L5 and S1 facet joint radio frequency denervation procedure. Petitioner reported increased mobility. Dr. Grochowski diagnosed Petitioner with cervical muscle spasm, lumbar spondylosis, and lumbar disc displacement. He prescribed Percocet and Baclofen and indicated that a lumbar epidural steroid injection would be appropriate if her symptoms for disc herniation persisted. On May 26, 2015, Petitioner returned to Dr. Grochowski who diagnosed Petitioner with lumbar radiculopathy and lumbar disc displacement, and recommended additional foraminal epidural injections in addition to a course of physical therapy.

On June 9, 2015, Petitioner began physical therapy at Pekin Hospital. She was initially evaluated by Janice Sigulas, PT. Therapist Sigulas recommended a course of physical therapy, 2 visits per week for 6 weeks, consisting of manual therapy, therapeutic exercise, therapeutic activities, e-stim, traction and ultrasound in conjunction with a course of aquatic therapy. Records from Pekin Hospital Rehabilitation Services indicate Petitioner attended physical therapy from June 11 through September 14, 2015.

Petitioner's employment with Respondent was terminated after exhaustion of her FMLA leave, on or about June 17, 2015.

On June 22, 2015, Petitioner presented to Dr. Shepherdson with complaints of continued low back pain. Dr. Shepherdson recommended an orthopedic consult.

On June 29, 2015, Petitioner presented to Dr. Grochowski with complaints of continued low back pain which radiated to her right hip. Dr. Grochowski diagnosed Petitioner with bilateral L3-S1 facet syndrome, L4-L5 left sided disc extrusion, radiculopathy and pain. Dr. Grochowski recommended continued physical therapy and administered an L4-L5 interlaminar epidural steroid injection.

On July 30, 2015, Petitioner presented to Dr. Grochowski. Dr. Grochowski diagnosed Petitioner with SI joint pain, pyriformis syndrome and herniation at L4-L5 with discogenic pain. Dr. Grochowski recommended a sacroiliac joint injection, trigger point injections for the left pyriformis muscle, and EMG testing.

On September 24, 2015, Petitioner presented to Dr. Grochowski. Dr. Grochowski diagnosed Petitioner with SI joint pain, pyriformis syndrome, and herniation at L4-L5 with discogenic pain. Dr. Grochowski recommended continued use of the prescribed pain medications in conjunction with a home exercise program. He further recommended a sacroiliac joint injection and left pyriformis muscle injection as well as EMG testing.

On October 21, 2015, Petitioner presented to Dr. Grochowski. Dr. Grochowski diagnosed Petitioner with SI joint pain, pyriformis syndrome, and a herniation at L4-L5 with discogenic pain. Dr. Grochowski administered a right sacroiliac joint injection under fluoroscopic guidance and a left pyriformis injection. Dr. Grochowski further indicated that EMG testing would be appropriate. Petitioner was released to return to work with restrictions which included a 15-minute break for every two hours worked, up to 8 hours per day.

On October 26, 2015, Petitioner presented to Dr. Zhou at Illinois Neurological Institute for evaluation of her continued low back pain. She reported that "she was fine the day of injury but several days later she had severe low back pain." (PX 3, p. 112) She reported pain across her low back, waistline, with intermittent radiation into her lower extremities. Her pain worsened with sitting, standing or bending over. Dr. Zhou noted that she had undergone a radiofrequency ablation, epidural injections, piriformis muscle injections, and SI injections. The doctor conducted an examination and reviewed the February 2015 MRI, which he noted showed a dark disk at L4-L5, lateral disk protrusion at L4-L5 causing lateral recess stenosis at that level to impinge on the L5 nerve root, and some facet joint arthropathy. Dr. Zhou assessed chronic low back pain. Dr. Zhou recommended physical therapy and activity modification and emphasized the importance of core strengthening.

On November 4, 2015 Dr. Grochowski recommended continued physical therapy in addition to another epidural steroid injection. Petitioner was placed on work restrictions which included working only 2 hours at a time with a break between with a maximum 8-hour day, five days a week. On November 30, 2015, Petitioner presented for a left L5 and Left S1 transforaminal epidural steroid injection.

On December 2, 2015, Petitioner returned to Dr. Grochowski. Dr. Grochowski noted "L4-L5 disc protrusion possibly related to fall patient had in January of 2015." (PX 8, p. 626) At this point Dr. Grochowski assessed L5-S1 left disc protrusion with left S1 radiculopathy, spondylosis of the L/S spine with bilateral facet syndrome and possible left sacroilitis. Dr. Grochowski recommended continued use of the prescribed medications in conjunction with a home exercise program as well as a left SI diagnostic injection which was scheduled for December 28, 2015. The Arbitrator notes this is the first notation in the records of Dr. Grochowski regarding an accident or injury.

On December 15, 2015, Petitioner presented to Dr. Grochowski with complaints of continued low back pain. Dr. Grochowski noted that Petitioner's "L4-L5 left lateral disc protrusion can be related to the fall patient had in January of 2015." (PX 8, p. 758) Dr. Grochowski further noted left S1 radiculopathy, based on her EMG testing results. Dr. Grochowski recommended a sacroiliac joint injection and an evaluation to determine whether Petitioner was a candidate for a spinal cord stimulator.

On December 28, 2015, Petitioner presented to Dr. Grochowski for a right sacroiliac joint steroid injection.

On January 13, 2016, Dr. Grochowski noted that Petitioner was scheduled for a psychiatric evaluation to determine whether she could go forward with placement of a spinal cord stimulator.

On March 14, 2016, Dr. Grochowski performed a Left S1 transforaminal epidural steroid injection.

On May 9, 2016, Dr. Grochowski placed a trial spinal cord stimulator. (PX 8, p. 636)

On May 28, 2016, Petitioner followed up with Dr. Grochowski. Dr. Grochowski referred Petitioner to Dr. McCall for neurosurgical consultation regarding placement of a permanent spinal cord stimulator as she had experienced moderate improvement with the trial spinal cord stimulator.

On May 25, 2016, Petitioner presented to the OSF St. Francis Emergency Department with complaints of severe back pain which she rated 10/10. The history reflects "female who has a [history of] chronic back pain presents to the ED for evaluation of back pain onset yesterday after partially bending down to wipe something up off the floor. Pt. states she feels like her whole back is swollen. She also reports dizziness from the pain and states that her vision was blurry while driving to the ED." (RX 10, p. 14) Petitioner related her prior low back treatment with Dr. Grochowski. A repeat MRI was performed and compared to the study of February 13, 2015. The impression was "1. Unchanged l4-5 left lateral disc bulge. No evidence of nerve root impingment. 2. Mild multilevel disc bulge and degenerative changes." *Id.* at 18 Petitioner was discharged and advised to follow up with her treating physician.

On June 15, 2016 Petitioner followed up with Dr. Grochowski and was advised to continue taking prescribed medications, continue her home exercise program and follow up with him in nine (9) months, or as needed.

On June 29, 2016, Petitioner presented to Dr. Todd McCall at Illinois Neurological Institute for a surgical evaluation. Dr. McCall recommended a left L4-L5 microdiscectomy prior to implantation of a permanent spinal cord stimulator. (PX 3, p. 102) Petitioner underwent the procedure on July 25, 2016.

Petitioner returned to Dr. McCall on August 31, 2016, reporting that her leg pain resolved after the lumbar decompression, but that she continued to experience back pain. Dr. McCall stated that there was no further surgical pathology of the spine, and he therefore recommended a spinal cord stimulator as a reasonable treatment option. Petitioner underwent the stimulator implantation on September 15, 2016.

On October 14, 2016 and October 26, 2016, Petitioner presented to Illinois Neurological Institute for a follow-up post insertion of the spinal cord stimulator. The history indicates "she was fine the day of injury but

several days later she had severe low back pain." (PX 3, p. 112) Petitioner reported that the radicular symptoms appeared improved but that she was still having pain across the low back and waistline sometimes with radiation into left lower extremity. She also reported some numbness and tingling in her left foot. *Id.* Dr. Zhou recommended activity modification and physical therapy. He also recommended that Petitioner continue to treat with her PCP and pain doctor for continued management of pain and therapy. He indicated that it was reasonable to continue to take pain medications and receive epidural steroid injections if the pain was severe. *Id.*

Petitioner testified that she returned to work at Royal Publishing in September of 2015. She testified that the job required her to sit for long periods of time either on the telephone or a computer. She testified she initially worked full time, for approximately one month. She stated she was unable to handle full time and Dr. Grochowski restricted the number of hours she could work. She testified she worked at Royal Publishing until April of 2016 when she was terminated because they did not have part-time work available. The Arbitrator notes, however that documents from Royal Publishing indicate she was hired on September 28, 2015 and last worked there on April 29, 2016. (RX 5) A review of the payroll records of Royal Publishing indicates that there was only one pay period in which Petitioner approached 40 hours per week. (RX 3) Royal Publishing disciplinary reports indicate Petitioner had 20 unexcused absences as of March 21, 2016. Four days later she received a one day suspension for absenteeism which Petitioner attributed to her daughter "running very high fevers." (RX 4) The records further indicate the type of separation was "voluntary resignation" and the reason for separation was "did not show or call." (RX 5) The Arbitrator further notes the records of Dr. Grochowski corresponding to visits during the period of Petitioner's employment by Royal publishing mention work restrictions only twice, on October 21, 2015 and November 4, 2015. On both occasions Petitioner was restricted to working 40 hours to week.[1]

Petitioner testified that as of the date of hearing she has remained under the care and treatment of Dr. Grochowski. Petitioner testified that the surgeries were successful in addressing her radicular pain symptoms, but did not completely resolve her low back pain. Petitioner testified her low back pain was 50-60% better with the spinal cord stimulator. Petitioner testified that she is required to follow up regarding the battery life and software of her spinal cord stimulator.

Petitioner testified that she had no prior low back pain or treatment predating January 20, 2015. On cross examination Petitioner specifically denied appearing at Pekin hospital in 2013 seeking treatment for back pain. She further reiterated her assertion that she had never experienced low back pain or radicular symptoms before the date of the accident. The Arbitrator notes that this is simply not true. Pekin Hospital records dated December 16, 2013 show Petitioner was seen at the emergency room for back pain which she rated of 10/10. The records reflect Petitioner's symptoms began when she was lifting heavy furniture and fell. She reported a pulling sensation in the low back. Further. the pain diagram indicates Petitioner had pain in the low back radiating down the back of her legs.

[1] The Arbitrator would point out that the records of Dr. Grochowski are contained in Petitioner's exhibit 8 which are the records collective records of Pekin hospital and the physicians affiliated with the hospital. The records consist of more than 500 pages and are difficult to read. The print is small on many pages, and others are very poor quality copies. Further the records are not in chronological order.

Petitioner also testified that she was unaware of any aggravating events occurring since January 20, 2015. She specifically denied recollection of visiting a hospital in May of 2016. As reflected above, on May 25, 2016, Petitioner presented to the OSF St. Francis Emergency Department with complaints of severe back pain which she rated 10/10. The history reflects "female who has a [history of] chronic back pain presents to the ED for evaluation of back pain onset yesterday after partially bending down to wipe something up off the floor. Pt. states she feels like her whole back is swollen. She also reports dizziness from the pain and states that her vision was blurry while driving to the ED." (RX 10, p. 14)

The evidence deposition of Dr. Grochowski was entered into evidence. Dr. Grochowski testified that on February 10, 2015 the history reported to the medical providers was that for the last two weeks Petitioner had been complaining of nonspecific lower back pain. (PX 7, p.11) When asked whether he saw Petitioner during her hospitalization from February 10 through February 13, 2015 he indicated it was most important to establish what day of the week she was admitted because he was only at the hospital Mondays through Wednsdays. Id. at 10. When it was determined that the day of admission was a Tuesday Dr. Grochowski testified that he had seen her on her floor after admission. Id. at 11.

Dr. Grochowski testified that his first impression was she had low back pain radiating to her lower extremity and "as far as I recall today, she stated something about falling, I'm not a hundred percent sure. I cannot say that - - what circumstances, but it was about fall and that her pain started abruptly during fall." Id. at 14. Dr. Grochowski testified he performed a brief examination because he remembered it was late at night. Id. He further indicated he did not order an MRI because "we already had MRI done" and that he had reviewed the report of the results. Id. The Arbitrator notes that Dr. Grochowski's consultation report says nothing about an injury of fall. (PX 8, pp. 242-248) The report further indicates that the encounter occurred at 16:40. Id. at 242. Additionally, the MRI was not performed until February 13, 2015, a Friday, when Dr. Grochowski was not at the hospital. Clearly Dr. Grochowski's recollection of his initial encounter with Petitioner is not at all reliable.

Dr. Grochowski reviewed the Pekin Hospital discharge records and testified that according to those records a urinary tract infection had been ruled out as the cause of Petitioner's symptoms. (PX 7, pp. 20-21) Dr. Grochowski testified that there was no history of low back pain, radicular symptoms or treatment before February of 2015. Id. at 43-44. He further testified that the findings reflected on the February 13, 2015 MRI may have existed before the date of accident. Id. at 44. When asked if the slip and fall in January of 2015 caused Petitioner's pain symptoms he stated "It's - - I don't know if it - - it can exacerbate conditions that she previously had and might have - - yeah, might start pain, yes. Yes, I agree." Id. at 46. When pressed Dr. Grochowski testified that it was more probably true than not that the slip and fall in January 2015 caused the pain in Petitioners low back. Id. at 47. Dr. Grochowski testified that the treatment provided to date was reasonable and necessary. Id. at 48. He further testified that Petitioner cannot currently work at a job where she must do frequent bending and twisting or lift 40 pounds. Id. at 42. Dr. Grochowski also testified that in his opinion she has reached maximum medical improvement a few months after her spinal cord stimulator was implanted, but that she has chronic pain and is not cured. He stated that he continues to treat Petitioner so that her condition does not deteriorate and stays stable. Id. at 68.

On cross examination Dr. Grochowski he would defer work capacity assessment to other specialists. Id at 50. He also admitted his causation opinion assumes Petitioner had experienced no prior problems with her

low back or legs. Id. at 51. He further admitted that the records associated with Petitioner's admission at Pekin hospital in February of 2015 indicate Petitioner's symptoms were not due to a fall or injury and that he had no knowledge of the details regarding Petitioner's fall. Id. at 56. Finally, he admitted that the condition and symptoms he has treated may not be related to a work accident, that the degenerative disc disease may have existed prior to January of 2015, any activities at work or at home could aggravate the condition reflected on the MRI and lead to treatment. Id. at 60-61.

The Arbitrator does not find the testimony and opinions of Dr. Grochowski regarding causation particularly persuasive.

The evidence deposition of Dr. Soriano, Respondent's section 12 examiner, was also entered into evidence. Dr. Soriano testified that the Petitioner's condition of ill-being and subjective complaints were not related to the describe work injury. He further opined that Petitioner needed no further medical care and could return to full duty work. Dr. Soriano testified at length regarding the hospitalization on February 13, 2015 for what was described as a severe kidney infection. Dr. Soriano testified that the complaints provided to the hospital were in no way related to any work injury. Dr. Soriano opined that the cause of Petitioner's back and right flank pain was pyelonephritis (kidney infection). The Arbitrator notes, however that Petitioner was treated for the kidney infection while hospitalized and the discharge notes reflect the infection had resolved, but Petitioner's pain persisted.

The Arbitrator does not find the testimony and opinions of Dr. Soriano regarding causation particularly persuasive.

CONCLUSIONS

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

Petitioner testified that on January 20, 2015, she slipped on grease that had spilled on the floor while working in the course and scope of her employment as a cook with Pekin Hospital. This recitation of events was corroborated by the statements of Respondent's employees. Accordingly, Petitioner has met her burden of proving by a preponderance of the evidence that an accident occurred 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?

As discussed above, the Arbitrator did not find the testimony and opinions of either Dr. Grochowski or Dr. Soriano regarding causation persuasive.

By Petitioner's own admission she did not complain of back pain or radiation on the day of the accident. When Petitioner was hospitalized on February 13, 2015, for what was described as a severe kidney infection, she did complain of back and right flank pain but did not mention any type of fall or injury.

Although Dr. Grochowski testified that time of his deposition he recalled that at the time of his initial evaluation "she stated something about falling," no mention of a fall appears in his records until December 2,

2015. In light of this inconsistence as well as the apparent faulty recollection of the doctor regarding his first evaluation of Petitioner discussed above, the Arbitrator does not find his testimony in this regard persuasive.

On April 1, 2015, Petitioner completed a Group Short-Term Disability Statement on which she indicated her disability was not due to her "occupation."

Petitioner testified that she had no prior low back pain or treatment predating January 20, 2015 and on cross examination she specifically denied appearing at Pekin hospital in 2013 seeking treatment for back pain. She further reiterated her assertion that she had never experienced low back pain or radicular symptoms before the date of the accident. The Arbitrator notes that this is simply not true. Pekin Hospital records dated December 16, 2013 show Petitioner was seen at the emergency room for back pain which she rated of 10/10. The records reflect Petitioner's symptoms began when she was lifting heavy furniture and fell. She reported a pulling sensation in the low back. Further, the pain diagram indicates Petitioner had pain in the low back radiating down the back of her legs.

Petitioner also testified that she was unaware of any aggravating events occurring since January 20, 2015 and specifically denied recollection of visiting a hospital in May of 2016. As reflected above, on May 25, 2016, Petitioner presented to the OSF St. Francis Emergency Department with complaints of severe back pain which she rated 10/10. Petitioner's testimony regarding her pre and post accident back complaints is not credible.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to the accident.

All other issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Brooks,
Petitioner,

vs. NO: 99 WC 35416

Prairie Packaging Co.,
Respondent.

18IWCC0457

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, occupational disease, wages, medical expenses, prospective medical treatment, 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).

The petitioner, pro se, asserted "permanent total disability" in the TTD section of the request for hearing form; the respondent disputed that, but did not dispute that the petitioner was due temporary disability following the accident through the trial date. The petitioner also checked off the section that the nature and extent of the disability was in dispute, but requested ongoing and specific prospective medical treatment under Section 8(a) of the Act. The Arbitrator correctly interpreted this request for hearing as a 19(b) petition and made no findings as to the nature and extent of the injury, noting that the award was not a bar to subsequent hearing and determination of additional medical benefits or compensation for temporary or permanent disability.

18IWCC0457

The Arbitrator noted in her decision that the claimant had been paid disability benefits throughout the course of the case to that point which would accrue to the respondent's credit, but did not specify a particular duration of disability. The Commission therefore adds the following language to the "Order" section of the Arbitrator's Decision:

The respondent shall pay the petitioner temporary total disability benefits of $252.49 per week for 895 & 4/7 weeks, from 6/18/1999 through 8/16/2016, as provided in Section 8(b) of the Act. Against this amount, the respondent shall be given a credit of $269,351.31 for disability benefits paid to date.

All other factual determinations and awards of the Arbitrator are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that other than as noted above, the Decision of the Arbitrator filed January 6, 2017, is hereby affirmed and adopted.

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

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

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

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

DATED: JUL 20 2018

Joshua D. Luskin

o-05/23/18
jdl-mcp
68

Charles J. DeVriendt

Elizabeth Coppoletti

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

BROOKS, JAMES Pro Se
Employee/Petitioner

Case# **99WC035416**

PRAIRIE PACKAGING CO
Employer/Respondent

18IWCC0457

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0000 BROOKS, JAMES
3624 PEACH GROVE
HAZELCREST, IL 60429

1401 SCOPELITIS GARVIN LIGHT HANSON
VICTOR SHANE
30 W MONROE ST SUITE 600
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
19(b)

JAMES BROOKS, *Pro Se*,
Employee/Petitioner

v.

PRAIRIE PACKAGING, CO.,
Employer/Respondent

Case # 99 WC 35416

Consolidated cases: N/A

18IWCC0457

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **8-16-2016**. 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. ☒ 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 **Specials, 8a/19b**

FINDINGS

On the date of accident, **6/18/1999**, 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 for the left hand, wrist, forearm, shoulder, right hand, wrist and shoulder and mental health conditions ***are*** causally related to the accident. Petitioner's current condition of ill-being for his neck/cervical spine, low back/lumbar spine and Hepatitis C ***are not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$19,693.96**; the average weekly wage was **$378.73**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$269,351.31** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$269,351.31**. Respondent is entitled to a credit of **$N/A** under Section 8(j) of the Act.

ORDER

Respondent is entitled to a TTD credit of **$269,351.31**.

Respondent shall authorize and approve the recommended prosthetic devices as noted by Advanced Arm Dynamics and Dr. Fakhouri.

Respondent shall authorize and approve the right shoulder, wrist and hand prospective medical treatment as recommended by Drs. Fakhouri and Mrozek.

Respondent shall authorize and approve the ongoing mental health treatment recommendations of Dr. Karimi.

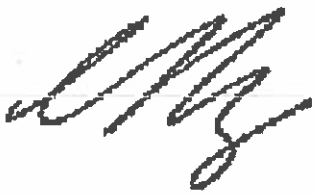
Petitioner is awarded **$205.00** in out-of-pocket expenses incurred at Tinley Park Pharmacy for prescriptions issued by Dr. Karimi on July 14, 2016.

Respondent shall pay reasonable and necessary medical services of Dr. Karimi in the amount of **$2,601.90**, as provided in Sections 8(a) and 8.2 of the Act. Against this specific award, Respondent shall be given a credit of for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit.

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

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

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



Signature of Arbitrator

12-29-2016
Date

ICArbDec19(b)

JAN 6 - 2017

FINDINGS OF FACT

Background

On August 16, 2016, James Brooks, *Pro Se*, ("Petitioner") proceeded to Arbitration against his employer, Prairie Packaging, Co., ("Respondent") on various disputed issues in connection with injuries he claims to have sustained on June 18, 1999 arising out of and in the course of that employment. At issue was: accident (as to shoulder, neck, back, right hand and Hepatitis C), causal connection (as to shoulder, neck, back, right hand and Hepatitis C), average weekly wage/earnings, medical bills and liability, Respondent credits and prospective medical care. Respondent's counsel clarified that Respondent did not dispute the left hand, wrist and forearm amputation but disputed the other conditions as claimed by Petitioner. Petitioner was current as to temporary total disability benefits as it related to the left hand, wrist and forearm injury. Each party was afforded an opportunity to make an opening statement. Petitioner was then sworn in. Given Petitioner's *Pro Se* status, the Arbitrator asked questions when necessary on some of the disputed issues.

Petitioner's Testimony

Petitioner testified that in 1999 he worked for Respondent as a line operator making dental wear. On June 18, 1999, his left hand, wrist and part of his arm were pulled into a grinder. The left hand was not recovered and he received immediate emergency care. Records showed Petitioner had no memory of the accident. Petitioner testified his co-workers donated blood.

He stated that after his wife died from colon cancer, that prompted him to get a physical in 2007 and that is when he discovered he had Hepatitis C. He denied ever being an intravenous drug user and testified he believed he contracted Hepatitis C from the transfusion(s) received during his emergency stay following his work accident. Petitioner explained he then began a long course of investigations into whether he had contracted Hepatitis C from any blood transfusions in June or July 1999. The Arbitrator asked Petitioner to point to which record or exhibit he had that demonstrated he was infected with Hepatitis C as a result of his blood transfusion(s) in June or July 1999. Petitioner was cross examined regarding the Hepatitis C claims.

Regarding his right hand, Petitioner alleges his carpal tunnel is the result of the work accident as he uses the right hand repetitively and almost exclusively. He says he has been recommended for a right carpal tunnel release. Regarding the right shoulder, Petitioner alleges his right shoulder is also the result of his work accident due to overuse of the right arm. He notes he has been recommended for a right shoulder surgery. Regarding the lumbar spine/low back, Petitioner said he believes his lumbar spine is related to his work accident because his whole upper body was snatched out of alignment at the time of the original work accident. He testified he has been recommended for pain management. Petitioner also stated there is a recommended lumbar spine surgery.

Regarding his average weekly wage, Petitioner testified he earned $11.92 per hour, that he worked 96 hours but was only paid for 80 hours of work each week. He held no other jobs at the time of his accident. He testified he had no paystubs or tax returns to submit. Petitioner claimed that due to Respondent's miscalculation of his average weekly wage earnings, he has been underpaid his temporary total disability benefits.

Regarding future medical care, Petitioner testified he needs additional Hepatitis C testing, a right carpal tunnel release, right shoulder surgery and back pain management.

18IWCC0457

Medical Treatment History

1999

Following his accident, Petitioner was transported for emergency care. Bedford Park Fire Department was dispatched and paramedics described a partial left arm amputation after Petitioner's arm was caught in a shredding machine with no parts able to be retrieved. He was started on intravenous (IV) therapy while in route to Christ Medical. Px2.

Records from Christ Medical describe a traumatic hand amputation to the left hand, forearm and fracture of the left forearm after the left hand was caught in a plastic grinder. The hand was not available as it apparently stayed in the machine and there was extensive injury of soft tissue, tendons, nerves, and vessels with obvious severe amputation injury. On June 18, 1999, Petitioner underwent irrigation and debridement of the forearm, wrist and hand, removal of extensive foreign body plastic debris, revision amputation in excision of the metacarpals one through five and excision of the median nerve, ulnar nerve and superficial radial nerve.

On June 19, 1999, Petitioner underwent a second surgical procedure. On June 20, 1999, Petitioner was evaluated by psychiatry at Christ Hospital and was diagnosed by Dr. Fishman with acute stress disorder. On June 20, 1999, Petitioner underwent a third surgical repair at or near the amputation site. On June 30, 1999, Petitioner underwent a fourth surgical procedure in the area of the amputation to remove necrotic tissue and additional debridement was performed in the stump of the hand, the wrist and forearm. On July 2, 1999, Petitioner underwent irrigation and debridement and wound closure of a completed left wrist amputation. Transfusion records were created for each procedure.

On July 6, 1999, Petitioner was formally discharged from Christ Hospital and was advised to follow up with Dr. Andreoni for infectious disease and Dr. Fakhouri for orthopedics. Social work also made recommendations for home care and ongoing mental health follow up. Christ Medical record noted that requests for transfusions were made on the following dates: June 18, 1999, June 20, 1999, June 23, 1999 and July 1, 1999.

On July 7, 1999, Petitioner began receiving home nursing care from TLI home healthcare resources. The service was eventually discontinued in December 1999 because Petitioner had not been home for two days in a row for his previously scheduled appointments in December 1999. Rx4.

On July 19, 1999, Petitioner followed up with Dr. Fakhouri. He showed good forearm rotation and supination and 75 degrees and pronation to 80 degrees. He was to continue range of motion and physical therapy. Discussion about a prosthetic device was had. Maximum medical improvement was estimated at 9 months to 1 year.

On August 2, 1999, Petitioner followed up with Dr. Fakhouri. There was weakness with pronation and supination. A prescription for a prosthesis and additional physical therapy was given. He remained off work. Petitioner reported ongoing flashbacks and he was recommended to continue with psychiatric treatment. On August 9, 1999, Petitioner attended physical therapy for the left stump. Patient also performed exercises to strengthen his upper extremity to include shoulder flexion abduction extension as well as biceps and triceps muscle groups. Rx1. Petitioner followed up on August 30 and was noted to have improved motion flexion within normal limits. Excision and debridement was discussed as an option prior to any fitting for prosthesis. Dr. Fakhouri expressed wanting a note from psychiatrist before any release would be made.

On September 10, 1999, Petitioner underwent scar revision. Rx3. On September 24, 1999, Petitioner followed up with Dr. Fakhouri. There was concern in the area of adhesions and Petitioner continued to report nightmares, insomnia and a lack of access to psychiatric care. The doctor continued to recommend formal counseling to evaluate for posttraumatic stress. The plan was for prosthetic fitting.

In October 1999, Dr. Fakhouri noted concern that skin in the area of amputation may be adhering to the bone. The plan was to continue physical therapy and consider alternative treatments. On October 18, 1999 there is a note that range of motion exercises included the shoulder, elbow and scapular region.

On November 24, 1999, Petitioner was evaluated by Dr. Robert Schenk at the request of Respondent. Rx2. The doctor noted that following amputation, Petitioner had hypersensitivity at the stump end and also at the mid-forearm level on the ulnar aspect caused by neuromata at the site of the transected nerves. Desensitization therapy was without success. In the doctor's opinion, Dr. Fakhouri's proposed radial forearm flap would not solve Petitioner's problems and instead suggested transfer of the neuromata to less sensitive areas of the arm, after which Petitioner would reach maximum medical improvement in six months. In the interim, he would not be able to use prosthesis due to hypersensitivity. The doctor noted he could return to one-handed work.

On December 4, 1999, Dr. Fakhouri performed a revision of the stump of the left wrist with excising of neuromas and scar revision. On December 13, 1999, occupational therapy notes noted progressively worsening left shoulder discomfort. Rx4. On December 17, 1999, Dr. Fakhouri noted that Petitioner's pain was nonexistent and wounds were healing nicely without signs of infection. Petitioner was fitted for prosthesis. The plan was to continue exercises. On December 30, 1999, physical therapy noted that Petitioner had a very painful left shoulder along with positive impingement with forceful flexion and horizontal abduction with internal rotation. Rx4.

2000

On January 4, 2000, occupational therapists noted complaints regarding the shoulder. Rx4. Additional complaints regarding the left shoulder appear in the record on January 5, January 7, January 12, January 26 and January 28. Rx4. On January 10, 2000, Petitioner underwent additional excision and scarring debridement. Rx4. On January 14, 2000, Petitioner returned to Dr. Fakhouri reporting significantly improved pain. Petitioner was ready for prosthesis fitting and it was recommended that he continue with therapy, ultrasound and desensitizing technique. Follow-up was scheduled. On January 28, 2000, Dr. Fakhouri noted that Petitioner was not improving with physical therapy and described shoulder complaints. MRI was ordered to rule out rotator cuff injury to the left shoulder.

On February 4, 2000, Dr. Fakhouri issued a referral to a psychiatric consult with Dr. Gnap. Px2. On February 11, 2000, Petitioner followed up reporting he felt better after talking with Dr. Gnap. He reported persistent shoulder pain and difficulty with movement and pain with day-to-day activities. Prescription for the MRI the shoulder was not yet approved. Dr. Fakhouri believed the left shoulder injury was related to the work accident. The plan is to continue therapy to the left arm.

On February 21, 2000, Dr. Thomas Long issued a Section 12 report at the request of Respondent. Rx3. The doctor concluded that Petitioner was an alcoholic. The doctor based this opinion on police records. The doctor further noted that there was a delay in reporting left shoulder pain, having first been noted on January 28, 2000 for which he found no causal connection to the amputation. He concluded that "given the history of alcoholism, his past behavior, the pain-free status of the patient by mid-December, and the lack of any

documentation regarding any shoulder injury until January 28, 2000, I would have to consider this a separate issue. I cannot prove the case, but I believe he injured his shoulder between January 14 and January 28, 2000 because he told Dr. Fakhouri he had no pain on January 14." On February 22, 2000, Petitioner underwent a left shoulder cortisone injection. Dr. Fakhouri again noted he believed the left shoulder was related to the work injury and continue to recommend physical therapy.

On March 10, 2000, Petitioner continued with significant left shoulder pain, positive impingement and rotator cuff weakness. The stump was less sensitive and wounds were healed. The doctor recommended that Petitioner continue with the prosthesis fitting but noted that he would need a fully functioning shoulder in order to work with the prosthesis. Follow up and MRI was recommended. On March 31, 2000, Dr. Fakhouri noted that the elbow and the forearm could not be rehabilitated due to left shoulder problems as they were more painful. Petitioner was developing frozen shoulder and had positive impingement sign. Dr. Fakhouri suspected either partial or complete tear of the rotator cuff and injected the shoulder with Cortisone.

On April 3, 2000, Dr. Fakhouri again noted that Petitioner was unable to rehab the elbow or forearm due to significant left shoulder pain. Px2. The doctor noted positive impingement sign on MRI consistent with complete or partial tear of the rotator cuff. Petitioner underwent another cortisone injection and. Px2. Dr. Fakhouri opined it was his opinion that the shoulder was related to the injury in amputation and recommended further treatment. Px2.

On April 8, 2000, Petitioner was admitted to Christ Hospital after attempting suicide by overdosing on medications. Dr. Farid Karimi was the psychiatrist on call that day and began treating Petitioner for symptoms of major and severe depression, anxiety and post-traumatic stress disorder. Px18. This treatment continued most recently through February 2016, at which time it was noted Petitioner was regularly following up for medication management. Px18.

On April 24, 2000, Dr. Preston Wolin performed a records review on behalf of Respondent. Rx4. He believed that Petitioner's shoulder MRI was consistent with a partial thickness rotator cuff tear of the supraspinatus tendon as well as hypertrophic changes. Dr. Wolin concluded that he believed Petitioner's shoulder pain was related to the period of immobilization that he underwent subsequent to the surgeries on his left forearm amputation. He noted this was a variant of shoulder hand syndrome which would at most consist of the possibility of capsulitis and should respond to a direct physical therapy program. He did not believe that the partial rotator cuff tear was causally related to the work injury or the period of immobilization. He recommended one-month trial of physical therapy. On April 25, 2000, Petitioner returned to Dr. Fakhouri. It was noted that Petitioner was in the hospital for two weeks after an attempted suicide. The doctor continued to recommend therapy for the entire left upper extremity including shoulder and fitting of prosthesis. Petitioner remained off of work.

On June 2, 2000, Petitioner followed up with Dr. Fakhouri. Shoulder was unimproved. Petitioner had received his prosthesis which he was able to use. There was a diagnosis noted of PTSD. On July 6, 2000, Dr. Karimi opined that within a reasonable degree of medical certainty was his opinion that Petitioner's psychiatric condition is a direct result of the work accident and subsequent amputation. Due to severity of symptoms, prognosis for complete recovery was guarded. The doctor recommended that Petitioner continue with psychotropic medications and therapy for an indefinite time.

On July 14, 2000, Petitioner returned to Dr. Fakhouri. Petitioner was crying and expressed no interest in continuing on with his life. Exam showed continued pain in the shoulder unimproved following injection. Dr. Fakhouri noted that Petitioner needed psychological or psychiatric clearance before considering a return to

work. In July 2000, Dr. Karimi noted that Petitioner had intense feelings of helplessness, hopelessness, frequent crying spells, anhedonia and physical pain. Px18. Diagnosis was major depression, single episode severe.

On August 11, 2000, Petitioner returned to Dr. Fakhouri. Px2. Petitioner complained of pain in multiple neuromas. Px2. Petitioner wished to proceed with neuroma surgery. On exam Petitioner had positive Tinel's in the area of neuromas. Regarding the shoulder, the doctor noted that Petitioner underwent two shoulder injections which improved his pain significantly but noted that when Petitioner wears the prosthesis it puts stress on the shoulder causing pain. At that time, the doctor did not recommend anything for the shoulder. The doctor continued to recommend a release from the psychiatrist. On August 28, 2000, multiple neuromas were excised operatively.

On September 27, 2000, a letter was issued advising that Respondent was able to offer Petitioner one-handed work for employment in the repack department. Rx5. On September 29, 2000, Petitioner followed up with Dr. Fakhouri. Petitioner was complaining of left shoulder pain with neuroma pain improving. There was noted loss of motion and loss of ability to weight bear. He still had pain over the shoulder with tenderness over the lateral aspect with positive impingement sign, limitation of shoulder abduction, forward flexion and external rotation. The doctor recommended therapy and strengthening exercises for the shoulder. The doctor noted Petitioner had undergone conservative care for the left shoulder and now recommended acromioplasty and rotator cuff repair. This particular treatment was held until recovery of the left forearm stump.

In October, 2000, Petitioner returned to Dr. Fakhouri reporting severe pain in the left shoulder and inability to move his arm. Overall function of the left arm was limited due to shoulder pain. Neuroma pains were improved. Exam demonstrated pain over the AC joint in the left shoulder with tender laterally. Petitioner had positive impingement sign and significant rotator cuff weakness he was unable to abduct shoulder more than 80° or flex beyond 90°. The shoulder had regressed and the doctor noted that all conservative treatment has failed. The doctor concluded that the MRI supported the diagnosis of rotator cuff tear. Petitioner wish to proceed with surgery. Procedure would include acromioplasty, cuff repair and possible joint resection.

On November 3, 2000, Dr. Fakhouri addressed the adjuster's concern regarding the shoulder, explaining that Petitioner sustained obvious significant traction injury affecting the entire left upper extremity. Px11. The doctor explained that as Petitioner's hand and forearm symptoms subsided, his shoulder condition became clearer and more prominent. The doctor noted Petitioner's prior medical history was devoid of any shoulder problems before the injury and it all came about after the injury.

On December 8, 2000, the left shoulder surgery was approved. On December 9, 2000, Petitioner underwent left shoulder surgery for impingement syndrome, acromioplasty and AC joint resection. On December 18, 2000, Petitioner followed up with noted improvement in the left shoulder. Physical therapy and home exercise were ongoing. On December 26, 2000, Petitioner followed up with Dr. Fakhouri. He was ordered to continue physical therapy and include pulley exercises with the left extremity.

2001

On January 22, 2001, Petitioner returned in follow-up. He reported shooting pain and discomfort in the palmar aspect of the forearm and sensitivities in the stump. He was to continue physical therapy. The doctor noted that the myoelectric prosthesis was not working and Petitioner was referred back to his prosthetist.

On February 14, 2001, Petitioner underwent an evaluation with Dr. Robert Schenk. Px14. It was his opinion that in regards to the neuroma, he did not feel that the surgical intervention had provided Petitioner with

any improvement and that Petitioner was at maximum medical improvement in regards to the left hand amputation. Dr. Schenk further stated that it was his opinion he did not feel that hand transplant would be ethical or appropriate. It was his opinion the Petitioner could return to one-handed work.

On February 26, 2001, Petitioner was evaluated by Dr. David Hartman at the request of Respondent. Rx6. Regarding his prosthesis, Petitioner related that he was dissatisfied noting that it only had three fingers to move and it was not practical. Petitioner also described difficulties with bathing and eating certain foods, social awkwardness, concentration, inability to perform competitive work due to constant pain in the left hand stump. He ate most meals in restaurants and avoids cooking food for fear of burning the house down. The doctor concluded the prognosis was generally poor because Petitioner so little chance for significant changes life. The doctor also noted that testing indicated or suggested that he attempted to minimize potential difficulties and feelings. The doctor further concluded that Petitioner's symptom profile is that most consistent with adjustment disorder. The doctor concluded that it did not appear that Petitioner had reached maximum medical improvement from a psychological perspective. The doctor recommended different type of psychotherapeutic treatments that what he was currently undertaking. The doctor expressed concern that Petitioner's recovery was being impeded by substance-abuse, having admitted to drinking a six pack of beer per day. Therefore, the doctor recommended a dual diagnosis program. The doctor for the recommended vocational training evaluation, behavioral psychotherapy and psychiatric evaluation.

On March 5, 2001, Petitioner advised Dr. Fakhouri that prosthesis was uncomfortable and not functional. The doctor noted that prosthesis limited forearm rotation and elbow motion. The rotator cuff was improved. He recommended a second opinion about the prosthesis. Px14. On March 15, 2001, medical case manager issued her progress report. In part, she assessed it remained her opinion that Petitioner had not indicated any motivation to wearing a prosthesis.

On March 30, 2001, Doris Kovachevich, certified hand therapist, certified work capacity evaluator and occupational therapist, wrote to Scheck Siress Prosthetics asking that consideration be given to Petitioner's functional limitations with regard to the prosthesis originally issued to him and to make the recommended modifications or fabrication. She enclosed a copy of the outside prosthetic consultation from Hanger Prosthetics and Orthotics as well as Dr. Fakhouri's prescription to implement the recommendations of that consult. Px14. In a letter to Petitioner's then attorney, Kovachevich indicated that Petitioner's complaints of a dysfunctional prosthesis were founded in clinical evidence due to the identified deficits of his current prosthesis. It was noted that Petitioner was unable to grade his prosthetic hand closer to the object being grasped such that closure on an object was either all or nothing. She further noted that a soft item will either be crushed or dropped also he could not retain grasp during activities requiring his arm to be placed overhead, behind his neck or behind his low back, etc. Px14.

On April 10, 2001, Petitioner returned to Dr. Fakhouri. Cortisone injection was administered for the neuromas. It was noted that Petitioner was not satisfied with his prosthesis and will not use it. Petitioner remained off of work. Px14. On May 11, 2001, Petitioner followed up with Dr. Fakhouri. Petitioner still had pain in the left shoulder but was improved. He continued to be unhappy with his prosthesis.

On June 8, 2001, Petitioner returned to Dr. Fakhouri and reported that he was evaluated by Hanger Prosthetics. Petitioner was prescribed additional physical therapy and follow-up. On June 20, 2001, disability management consultant issued a second progress report. That report now noted that Hanger Prosthetics have concluded that Petitioner's current prosthesis was inappropriate. The prosthesis limited Petitioner's function and prohibited him from doing more than he could without the wearing of the prosthesis. The prosthesis was noted to cover Petitioner's elbow, subsequently limiting flexion, pronation and supination. They also concluded

that the prosthesis limited shoulder motion for Petitioner. In addition, the prosthesis was noted to be very large in diameter preventing wearing of the prosthesis with any clothing that had sleeves including an outer coat for the winter. The nurse's assessment now was that it was her opinion that the device may post some functional limitations for Petitioner and a new prosthesis would allow more function. She remained pessimistic about Petitioner's compliance toward successful recovery. Px14.

From August through December 2001, Petitioner continued to follow up with Dr. Fakhouri and physical therapists. He reported whether sensitivity and discomfort in the forearm and stump. He was still being fitted for prosthesis. The doctor recommended work conditioning and a functional capacity evaluation in order to determine what Petitioner could and could not do. The doctor further recommended vocational re-educational program. He was noted to still be seeing a psychiatrist and recommended that he continue.

2002

On February 5, 2002, a functional capacity evaluation (FCE) suggested the presence of submaximal effort, questionable reliability and accuracy of subjective reports of pain and limitation report concluded that Petitioner was not capable of performing his preinjury job machine operator phone line operator. Petitioner's current lifting tolerance was less than sedentary physical demand level. Therapist further noted that self-limiting behavior included not bringing his prosthesis or using the left or to assist with any tasks. Rx8.

On February 8, 2002, Petitioner returned to Dr. Fakhouri with ongoing occasional discomfort in the left shoulder and stump. Petitioner had recently attended the functional capacity evaluation and the doctor estimated the Petitioner had reached maximum medical improvement. Restrictions were per the functional capacity evaluation but noted the FCE was limited. The doctor noted that Petitioner still needed to continue with a prosthetic. Rx9.

On March 12, 2012, Petitioner underwent a second FCE at Accelerated Rehab. Rx10. The results were considered valid and represented fair to good effort demonstrated by Petitioner. The report noted that Petitioner was extremely self-limiting with regard to the use of his left upper extremity in a variety of functional tasks where he could have utilized his stump as an aid or support of the right upper extremity while performing during this exam. He also demonstrated inconsistencies with his active range of motion of the left shoulder. The report concluded that Petitioner was employable in a position that is currently a sedentary work level with the use of the bilateral upper extremities was not required to perform essential job demands.

On June and July 2002, Petitioner's doctor, Dr. Karimi opined Petitioner's mental health conditions and symptoms were a direct result of the injury sustained. At that time, Dr. Karimi noted depression, anxiety, flashbacks, nightmares helplessness and hopelessness. Petitioner's depression has been so severe that it had at times manifested psychotic features. Maximum therapeutic dosages of various psychotropic medications produced minimal response and the doctor opined that Petitioner would require monthly to bimonthly medication management and continuous psychotropic medications. He also anticipated likely future care related thereto. Px18. He concluded that Petitioner's psychological disabilities work will be lifelong and would require psychotropic medications for life.

On September 30, 2002, Petitioner returned to Dr. Fakhouri. There was good range of motion in the elbow and forearm and rotation. Petitioner was to continue using the prosthetic. The doctor noted that there was nothing more to offer by way of treatment. He was to follow up as needed. Rx9.

2003

On February 14, 2003, Petitioner returned to Dr. Fakhouri. Petitioner was ordered to continue with the limitations from the FCE and follow-up as needed. Petitioner was injected with Cortisone in the two areas of complaints.

On December 18, 2003, Dr. Henry Lahmeyer issued his report after performing a record review at the request of Respondent. Rx11. His findings were addressed to then Respondent attorney Michael Brennan. Diagnostic impression was history of acute stress disorder, severe alcohol dependence, severe marijuana dependence and nicotine dependence. Additional diagnostic impressions included personality disorder with passive antisocial traits, narcissistic and some paranoid traits. The doctor concluded the Petitioner appeared to have some symptoms of depression and social withdrawal but the symptoms are now due to severe alcohol and marijuana addiction. The doctor further noted that alcohol had led to a variety of symptoms and problems. The doctor noted that it was clear that after his amputation Petitioner began to drink heavily and became pessimistic about ever working again. He was also faced with a series of various stressors. The subsequent stressors in the opinion of the doctor were greater than the stress of losing his hand. The doctor did not believe Petitioner had any remaining psychiatric symptoms directly caused by the accident. However, his alcoholism was in part a result of his past history of heavy drinking while in the military, family history of alcoholism and his own antisocial, angry attitude and his own choice to attempt to control his own feet and reject help offered. Recommendations were made for addressing the alcoholism.

In 2003, when Dr. Karimi was deposed, he concluded that Petitioner's trauma was psychologically and physically irreversible and was severe. He opined that Petitioner would require continuing medical attention in the future as summarized in his June 2002 letter. The doctor for the testified that Petitioner psychological disabilities will be lifelong and he would continue to require ongoing psychiatric treatment by way of medication management sessions as well as therapy sessions. The doctor further concluded that he did not believe Petitioner could function without such medications. The doctor further explained the Petitioner would likely need earlier nursing home placement and reiterated that he concluded Petitioner's depression and post-traumatic stress disorder were caused by the amputation injury. Px18.

2004

No records were submitted into evidence at Arbitration.

2005

On May 6, 2005, Expediter Corporation issued correspondence to Petitioner regarding assistance in obtaining employment to work from his home. Rx12. In October 2005, Petitioner treated at Advocate South for unrelated right ankle bi-malleolar fracture and fixation, sustained after stepping into a hole while walking. Px10.

2006

On April 17, 2006, Petitioner returned after three years of no visits to Dr. Fakhouri with bilateral shoulder weakness, pain and neck pain. There were no neuromas in the left stump. Petitioner had positive Tinel's sign over the radial aspect of the distal forearm and in the area of the superficial radial nerve. In addition, there was positive Tinel's in the ulnar aspect of the forearm. Exam of the neck was non-tender. There was weakness in external rotation and forward flexion of both shoulders. X-rays were unremarkable of the

shoulder, cervical spine and left forearm stump. Impression was superficial radial neuroma, medial antebrachial cutaneous neuroma of the left forearm and bilateral shoulder pain and weakness. The doctor recommended MRI of both shoulders, physical therapy for both shoulders and MRI of the neck. MRI of the cervical spine showed predominately degenerative changes and MRI of the right shoulder showed partial thickness tear and AC joint arthrosis. Px11. MRI of the left shoulder was negative.

On May 15, 2006, Petitioner returned to Dr. Fakhouri. Petitioner reported 60-70% improvement following injections. Prescription for the prosthesis new was given. He was referred to Dr. Lim. On May 23, 2006, Dr. Richard Lim issued a note at the referral of Dr. Fakhouri. Petitioner reported chronic neck pain since the accident date starting in the traps and radiating up into the paraspinals and suboccipital area. Pain did not radiate. Left shoulder pain from the accident has not yet resolved. Exam was non-focal and there was no evidence of rotator cuff tear on MRI. Dr. Lim believed Petitioner had myofascial pain syndrome and no surgery was indicated. He recommended physical therapy first and if there was no relief, then epidural injections.

2007

Over one year later, on September 11, 2007, Petitioner first saw Dr. Curry of Heather Medical Associates. Px6. He was diagnosed with posttraumatic stress which is currently being treated and lower back pain. Px6. The plan was for an x-ray of the lower back. X-ray of the lumbar spine and indicated degenerative changes of the lumbar spine. Px6, 10.

On October 3, 2007, Petitioner treated with Dr. Bhatia at the referral of Dr. Curry. Px5, Rx13. Petitioner was scheduled for a liver biopsy and a colonoscopy. Px5. Following abnormal liver enzymes it was revealed Petitioner had chronic Hepatitis C. Px5. Petitioner had a noted history noted blood transfusions 1999 and intravenous drug abuse 20 years ago. Impression was chronic Hepatitis C. Px5. MRI of the lumbar spine was ordered, which showed degenerative changes. Px6, 10-11. Related to his Hepatitis C, Petitioner began a course of treatment with South Suburban, Oak Forest Hospital, Dr. Curry and Dr. Bhatia for various related treatments, including ultrasound of the kidneys, biopsies, regular lab testing, gastrointestinal follow up and speech pathology in 2008, 2010, 2011 and 2012. Px6, 8, 10. RX 18-19.

2008

In March 2008, lab testing performed by ACL Laboratories did not detect Hepatitis C RNA. At the end of the treatment on June 25, 2008, HCV viral load was negative and measure to get in December 2008 and had no evidence of Hepatitis C virus. Px5.

On April 1, 2008, Petitioner treated with Dr. Mark Chang of Midwest spine care at the referral of Dr. Curry. Px6,11. It was noted Petitioner had a long-standing history of lower back pain radiating into the right groin and that he "does not recall any specific event or injury to initiate the pain." Px6. Impression was chronic lower back pain secondary to L5-S1 severe disc degeneration and stenosis. Px6. The doctor reviewed the MRI and did not find any neurologic problems and instead recommended a course of physical therapy and follow up. Px6. In June, August and December 2008, testing from ACL laboratories suggested that Hepatitis C was not detected. Rx16.

On December 4, 2008, Petitioner was admitted to South Suburban Hospital on an emergency basis following psychiatric incident. Rx15. A request for involuntary admission was made by the attending doctor and he was eventually transferred to Methodist. From December 5, 2008 through December 8, 2008, Petitioner treated with Methodist Hospital of Chicago following admission on an emergency basis for depression disorder,

posttraumatic stress disorder, chronic Hepatitis C without hepatic coma, alcohol abuse, cannabis abuse, tobacco use disorder, pain amputation status and late affect dramatic amputation. Px7. It was noted that Petitioner was involved in an unrelated custody dispute involving his daughter and he was eventually released from care. Px7. On December 23, 2008, Dr. Bhatia concluded that Petitioner had no evidence of Hepatitis C virus. Px5, Rx17.

2009

In July 2009, Dr. Fakhouri again referred Petitioner to his prosthetist regarding his questions about prosthetics.

2010

On September 23, 2010, Petitioner returned to Dr. Fakhouri requesting a prescription for a new prosthesis. The doctor wrote a prescription for prosthesis which is not his area of specialty and again referred Petitioner to a prosthetist.

In October 2010, Department of Health and Human Services ("DHHS") concluded that its investigation failed to reveal any indication that any of the units of blood actually used were in fact objectionable or otherwise had any special attributes indicative of or consistent with Petitioner's assertion that he contracted Hepatitis C. Px4. Prior memorandums were issued in January and May 2010. See Also, Px3.

On October 20, 2010, Dr. Karimi opined Petitioner had considerable difficulty psychologically adjusting to the loss of an arm. Px18. The doctor further noted that Petitioner's depression lead to suicide attempt in April 2000. He did not appear to be responding to internal stimuli but also did not appear to be psychotic. Based on a reasonable degree of psychiatric certainty, Dr. Karimi concluded that Petitioner was suffering from post-traumatic stress disorder as a direct result of the work accident. Further concluded that Petitioner has been unable to perform work duties with or without accommodation. The doctor further noted that 30% of individuals with PTSD developing chronic course of illness with periods of acute exacerbations. He concluded that Petitioner's condition and symptoms met the criteria for this type of chronic course. The doctor further concluded that Petitioner had also developed symptoms of major depression along with PTSD. Describing these as co-morbid psychiatric conditions including major depression, generalized anxiety disorder, panic disorder or Agoura phobia. The doctor concluded prognosis was poor for complete recovery from a psychological condition. In November and December 2010, Petitioner presented to Christ Hospital ultimately treating for neck pain. Rx20, Px11.

2011

On January, March and April 2011, Petitioner submitted to Christ Hospital and treated for low back and neck pain. Px11. In April, Christ diagnosed Petitioner with carpal tunnel syndrome.

On March 17, 2011, Hanger Prosthetics and Orthotics noted that Dr. Fakhouri had prescribed a left transradial electric prosthesis. The second evaluation had recently been performed February 9, 2011. Petitioner had a left transradial upper limb absent secondary to a work-related amputation. The current prosthesis at that time was a left electric prosthetic system that was approximately 10 years old that Petitioner reported was heavy, a poor fit and had poor function. Petitioner reported the following difficulty with the old prosthesis: putting on and removing T-shirts, attaching the end of zipper jacket, zipping a jacket, tying shoelaces, preparing a light meal, carrying laundry baskets, buttoning a shirt with front buttons, putting on socks, full body bathing, cutting

meat with a knife and fork, using a hammer and nail, folding a bath towel, driving a car and opening an envelope. There were also reported problems with poor socket fitting, poor suspension, heavy weight, poor control, decrease in volume and limited range of motion. A new myoelectric prosthesis was recommended. Px13.

On October 18, 2011, Petitioner treated with Advanced Arm Dynamics for occupational therapy. Diagnosis was left long transradial 2 inches from the wrist amputation. History noted that Petitioner had previously been given prosthetic device from Hanger but it was ultimately rejected due to lack of functionality. Petitioner also reported constant pain and bilateral upper limbs and spine due to the body being twisted during the accident.

On November 2, 2011, Advanced Arm Dynamics issued a written request for authorization for approval prosthetic evaluation and device. At that time, Petitioner was recommended for four forms of prosthetic management. Costs and rationale were explained and provided. Px15. On November 23, 2011, Sedgwick issued utilization review and non-certification regarding left preparatory definitive transradial level myoelectric prosthesis. Rationale and explanation was given. Px15, Rx21.

2012

On January 5, 2012 EMG of the right upper extremity showed evidence of mild median and ulnar sensory neuropathies at the right wrist. Px10. There was no evidence of fiber polyneuropathy or cervical radiculopathy affecting the right upper extremity.

On May 18, 2012, MRI of the right wrist was consistent with carpal tunnel syndrome. On July 27, 2012, Advanced Arm Dynamics issued a letter expressing concern over new and thinner batteries for the Michelangelo Arm prosthetic. Px15.

On November 13, 2012, Petitioner underwent a section 12 evaluation at the request of Respondent with Dr. Prasant Atluri. Px9, Rx22. Petitioner gave a history of his work accident and reported that following the work accident he was forced to rely upon his right hand for daily as well as work-related activities. Two years prior to the exam, Petitioner began to notice progressively worsening weakness in the right hand and developed tingling. He denied any prior history. The doctor noted triggering of the right ring finger with tenderness at the ~~A1 pulley of that digit, negative Tinel's and no tenderness over the cubital tunnel. He reviewed x-rays and~~ MRIs and concluded that Petitioner has numbness and tingling in the right hand as well as complaints of weakness which are of unclear etiology. The doctor also concluded Petitioner had limited objective findings which did not correlate with subjective complaints making specific diagnoses impossible. The doctor concluded that Petitioner's right upper extremity complaints were not related to the 1999 work accident.

On September 30, 2013, Advanced Arm Dynamics issued its written request for authorization for specific prosthetic devices in light of Petitioner circumstances. Px15. Rationale and costs were explained in the documentation. On October 4, 2013, Sedgwick issued its letter to Advanced Arm Dynamics indicating that the preparatory and definitive transradial level myoelectric prosthesis for the left arm was medically certified by peer review. Px15.

2014

On May 6, 2014, Petitioner returned to Dr. Fakhouri. Px9. He complained of tingling numbness and pain in the right hand. The doctor noted that back in May 2012, there was discussion of a right carpal tunnel

release. The doctor opined that "his present condition is related to overuse of the right hand because of the loss of his left hand." Conservative care for the right hand was recommended. He was to follow up as needed. On May 8, 2014, Dr. Fakhouri issued a statement of medical necessity in reference to the revise recommended prosthetic devices issued by Advance Arm Dynamics. The doctor recommended in full the prosthetic devices as outlined by Advanced Arm Dynamics.

On May 22, 2014, Pat Prigge, clinical manager with Advance Arm Dynamics, wrote identical letters to both Sedgwick and Dr. Fakhouri outlining recent prosthetic evaluation and ultimately requesting authorization for same. Px15. Based on Petitioner's type of amputation and required functionality, it was recommended that Petitioner be fitted with three forms of prosthetic management, which included 1) a functional myoelectric prosthesis, 2) a rugged activity specific prosthesis and 3) a waterproof bathing prosthesis. The report noted that Petitioner was previously fitted with prosthesis shortly after the injury but was never able to utilize it. He often relied on the intact arm and hand for functioning and was experiencing symptoms of overuse. There was a prior recommendation for certain prosthesis but the situation has now changed and current recommendations were based on specific requests from the Petitioner and what was currently available on the market. The changes no longer recommended the Michelangelo hand, in part. The author concluded that all of the recommended devices served a unique purpose and will optimize level of functional outcome. It was noted that Petitioner was originally given prosthesis but had not been given insufficient training on how to use utilize the prosthesis and ultimately rejected. Petitioner discontinued using it and relied on the right hand for function. Additional considerations given were limited range of motion due to shoulder pain, limited flexion extension, psychological and psychiatric injuries, overuse syndrome including rotator cuff injury, carpal tunnel syndrome, cervical neck pain, shoulder pain and peripheral apathy. Rehabilitation goals and prosthetic requirements were also outlined. A prosthetic rehabilitation plan was outlined. The clinical manager explained the specific use for each of the three recommended prosthetic devices and listed contraindications for body powered prostheses.

On June 13, 2014, Petitioner followed up with Dr. Fakhouri. Px9. Petitioner was referred out for the right shoulder, neck and back. On June 23, 2014, Advance Arm Dynamics issued a written request for authorization for certain specific prosthetic devices. Rationale and costs were provided. Also attached was a letter of medical necessity issued by Dr. Fakhouri in connection with the document. Px15.

On July 2, 2014, Sedgwick denied as noncertified the left preparatory and definitive trans radio level waterproof beating activity specific prosthesis, left preparatory and definitive trends radio level heavy-duty activity specific prosthesis and left trans radial level my electric prosthesis with preparatory procedure. Px12, 15. Clinical summary indicated that Petitioner was initially fit with the prosthesis after the injury but reportedly was never able to utilize it. He had symptoms of overuse on the intact arm and hand. Per the prosthetist, body power prosthesis was not recommended due to amputation level and functional requirements. Similarly cable driven prosthesis would likely exacerbate existing injuries. The physician noted that Petitioner had requested prosthesis and that he had ongoing pain in the right shoulder that has progressively become more severe. He had undergone multiple cortisone injections and also was reporting neck and back pain. The denial was based on no clear documentation for the provider that Petitioner was unable to function with body power prosthesis. Further, denial basis noted that Petitioner has had previous prosthesis fitted and it was not indicated why does cannot be used therefore the prosthesis was noncertified. The document was signed by Dr. Khiem Dao, licensed in the state of California.

On September 10, 2014, Sedgwick issued a letter to Advance Arm Dynamics upholding the original non-certification for the 3 recommended devices. Px15. In September 2014, Dr. Fakhouri continued to see Petitioner and diagnosed bilateral impingement syndrome of both shoulders, rotator cuff weakness in right carpal tunnel syndrome. Px9, 11. The doctor noted that Petitioner was only using his right hand and does not

have prosthesis for the left upper extremity. Px9. The doctor opined that Petitioner was a candidate for carpal tunnel release. Regarding the right shoulder, again he continued to be symptomatic and was referred out.

On October 3, 2014, Advance Arm Dynamics submitted additional materials in relation to its appeal of Sedgwick's decision regarding non-certification of the prosthetic proposal. The letter noted Sedgwick's denial based on: 1) no clear documentation from the provider that the claimant was unable to function with body powered prosthesis and 2) that Petitioner had had a previous prosthesis fitted and it was not indicated why that cannot be used. The document noted that these concerns were previously addressed in September 2013 at which time Sedgwick approved the then-proposed device. The letter pointed out that Petitioner had was not given sufficient training on how to use the device, the prosthesis limited ability to pronate and supinate his forearm, the hand only had a three jaw chuck grasp and the prosthesis fell off of the arms due to poor fitting.

On October 14, 2014, Petitioner was evaluated by Dr. Beverly Brisbin for neck and low back. Px9. On October 20, 2014, Petitioner followed up with Dr. Brisbin. Impression was cervical and lumbar radiculopathy. Petitioner elected to proceed with pain clinic evaluation and possible epidural injections. On October 29, 2014, Petitioner was reevaluated by Dr. Mrozek for the right shoulder. Px9, 11. Exam was difficult secondary to pain. Assessment was right shoulder pain. The doctor recommended a new MRI, which showed partial thickness tear of the supraspinatus and infraspinatus as well as degenerative labral tear and moderate degenerative disease of the AC joint.

2015

On April 30, 2015, Petitioner was evaluated by Dr. Avi Bernstein at the request of Respondent. Px9, Rx25. The doctor opined that relative to the low back and neck, Petitioner had minor degenerative changes of the cervical spine and more advanced degenerative changes at the L5-S1 level in the lumbar spine but otherwise benign conditions of both areas. The doctor did not believe either area required significant treatment or there was no causal connection between Petitioner's condition of either the cervical or lumbar spine and his work accident of June 18, 1999. In February 2016, the parties took the evidence deposition of Dr. Bernstein, who testified consistently with the findings and opinions contained in his original report. Rx33.

On May 7, 2015, Petitioner underwent section 12 exam with Dr. Shirley Conibear at the request of Respondent. Px9, Rx26. The doctor concluded there was no objective evidence linking Petitioner's Hepatitis C, which was resolved, to his work accident or any transfusion record. The doctor testified consistent with her report. Rx34. On May 29, 2015, Petitioner was examined by Dr. Howard Konowitz at the request of Respondent. Px9, Rx27. He diagnosed right shoulder pain, mechanical low back pain, carpal tunnel syndrome on the right, left arm amputation and psychological factors affecting medical condition. The doctor causally related to left arm amputation to the accident. Regarding the cervical spine, lumbar spine and leg symptoms and Hepatitis C, the doctor opined that they were not consistent with the mechanism of injury and records presented. The doctor deferred psychological assessment. Regarding additional treatment, the doctor requested left arm prosthetic records to be reviewed as Petitioner alleged improper arm prosthesis provided. In December 2015, the parties took the evidence deposition of Dr. Konowitz, who testified consistently with the findings and opinions contained in his original report. Rx31.

On June 9, 2015, Petitioner was once again reevaluated by Dr. Atluri. Px9, Rx28. He examined the left shoulder, right shoulder, right hand. The doctor concluded the Petitioner was malingering and misrepresenting his condition. Nevertheless, clinical documentation and objective findings suggested chronic impingement syndrome of the right shoulder and right carpal tunnel but that such objective findings were age-appropriate findings as he did not identify any signs of any condition which was accelerated or caused by overuse of the

right upper extremity due to compensation for his deficiencies in the left upper extremity from his severe traumatic injuries. In 2016, the parties took the evidence deposition of Dr. Atluri, who testified consistent with his 2012 and 2015 reports. Rx32.

On September 21, 2015, Petitioner returned to Dr. Fakhouri. Px9. He noted there was a recommended right shoulder surgery and right wrist surgery. Dr. Fakhouri injected the right wrist and continued to opine that the right upper extremity conditions were related to overuse because of the amputation to the left upper extremity. Px11.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only witness to testify at live at trial. The Arbitrator finds Petitioner credible as to his mechanism of injury, recollection of ongoing medical care and as to his subjective belief as to his need for ongoing care.

ISSUE (C) ***Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?***
ISSUE (F) ***Is Petitioner's current condition of ill-being causally related to the injury?***
ISSUE (K), (O) ***Is Petitioner entitled to any prospective medical care?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, Respondent's counsel stated on the record and stipulated to Petitioner's left hand wrist or forearm injuries indicated that those conditions were not in dispute. The dispute regarding accident and causation is as to Petitioner's shoulder, neck, back, right hand and Hepatitis C condition(s).

a. Left Hand, Wrist and Forearm

In light of the stipulations and available medical evidence, the Arbitrator concludes that Petitioner's left hand, wrist and forearm conditions are causally related to the undisputed work accident June 18, 1999. In so finding, the Arbitrator relies upon the emergency room records following Petitioner's mechanism of injury which clearly document Petitioner suffered a severe and traumatic injury whereby his left hand became caught and pulled into a work machine. This injury eventually resulted in the amputation of the left hand into the mid forearm of Petitioner's left upper extremity. This initial injury forms the basis of Petitioner's allegations regarding all subsequent injuries and/or conditions as addressed below.

Despite the stipulation as to accident and causation, Respondent disputes Petitioner's ongoing need for prospective medical treatment in the form of various recommended prosthetic devices. In this regard, the Arbitrator concludes that Petitioner has proven by a preponderance of the credible evidence that he is in need of and entitled to new prosthetic devices as recommended by Advanced Arm Dynamics. Petitioner was given a prosthetic device sometime in 2001, which was delayed due to left shoulder problems, but was ultimately rejected by Petitioner because he felt it was of little functional use. Petitioner gave specific examples as noted in records as to the original device's lack of functionality, noting that it only had 3 fingers, made gripping and grasping all or nothing resulting in an inability to articulate fingers individually, the size at the elbow made putting on long sleeves and winter jackets nearly impossible, that the straps caused further left shoulder pain and symptoms and that he was unable to move freely in certain planes. Advanced Arm Dynamics supplemented Petitioner's complaints by noting that inadequate training was given for the original prosthetic.

In June 2001, Respondent's case manager and Hanger Prosthetics determined that Petitioner's original prosthetic was inappropriate. Reports noted that the original prosthesis, limited function, covered the elbow subsequently limiting flexion, pronation and supination and limited shoulder motion. In addition, the prosthesis was noted to be very large in diameter preventing wearing of the prosthesis with any clothing that had sleeves including an outer coat for the winter. Px14.

Petitioner returned to treatment in 2006 for left upper extremity related treatment and eventually, a new device was requested sometime in 2011. By all accounts, the record suggests Petitioner was without any left hand prosthetic device from mid-2001 to 2011, when a new one was requested. Eventually only the preparatory and definitive transradial level myoelectric prosthesis was approved in 2013. In May 2014, Advanced Arm Dynamics issued a revised report ultimately requesting 3 separate devices for Petitioner based on change circumstances, including market availability, each of which had specific functions for the left arm, all designed to aid in successful functionality. By this time, Petitioner had been without left hand prosthetic device from 2001 through 2014. Specifically, Advanced Arm Dynamics a functional myoelectric prosthesis, a rugged activity specific prosthesis and waterproof prosthesis for bathing. The requested devices were ultimately non-certified in 2014. Advanced Arm Dynamics timely appealed the non-certification, which was upheld.

The Arbitrator resolves the dispute over the prospective left hand prosthetic devices in favor of Petitioner, noting that Advanced Arm Dynamics correctly pointed out that the 2014 non-certification rationale was previously addressed resulting in favorable certification in 2013. Advanced Arm Dynamics' rationales for each of the devices, which are supported by Dr. Fakhouri, are sound and fully supported by the record. The Arbitrator finds that Respondent's 2014 non-certification of the recommended devices unsupported by the weight of the evidence. Further, the Arbitrator notes that Respondent did not deny the proposed devices because they were excessive and/or unnecessary but rather denied the devices because there was allegedly insufficient evidence provided to show that another or that the original device was not adequate. 820 ILCS 305/8.7(i)(3). Without any new prosthetic device, which has been recommended since 2001, the Arbitrator finds it difficult to conclude Petitioner has reached maximum medical improvement as to the left hand amputation injury and declines to adopt any conclusion that he has. Therefore, Respondent shall authorize and approve the recommended prosthetic devices as noted by Advanced Arm Dynamics and Dr. Fakhouri.

b. Right Hand, Wrist and Forearm / Right Upper Extremity

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator has carefully considered all available medical evidence in concludes that Petitioner has proven by a preponderance of the evidence that his right upper extremity, which include his right shoulder and hand/wrist conditions are causally related as a sequela of the original work accident.

In so finding, the Arbitrator places greater weight in emphasis on the medical opinions of Dr. Fakhouri over those of Dr. Atluri. Dr. Atluri in part concluded that Petitioner's right extremity conditions while demonstrable on objective findings on various exams were nevertheless in his opinion age-related and in no way a consequence of the work accident. The Arbitrator is not persuaded by this conclusion and declines to adopt this position. Dr. Atluri concluded there was no relationship between Petitioner's right upper extremity overuse and/or repetitive use but failed to provide any detailed explanation as to why. Further, it does not appear that Dr. Atluri considered the fact that Petitioner had undergone left shoulder surgery and was without any functional and/or approved left arm prosthetic device from 2001 through at least the time of his initial evaluation in 2012.

The most persuasive medical explanation given is by Dr. Fakhouri, who pointed out that Petitioner's right upper extremity symptoms which include the right shoulder, hand and wrist all emanate from an overuse or

compensation as a result of the severe and traumatic injury Petitioner suffered to the left hand, wrist and forearm. Petitioner's complaints of right shoulder and right hand/wrist pain due to overuse appear consistently in the records of Dr. Fakhouri, Advanced Arm Dynamics as well as the July 2014 non-certification clinical summary issued by Sedgwick.

Petitioner, upon returning to treatment in 2006, began reporting to various providers that he uses his right extremity for nearly all activities. The Arbitrator finds these complaints supported by the lack of approved left hand prosthesis between 2001 and 2006. Further, Dr. Fakhouri had noted a delay in fitting for the original prosthesis due to Petitioner's left shoulder symptoms from 2000 to 2001.

Also of note, the Arbitrator observed that at trial, Petitioner presented at Arbitration without any prosthetic device whatsoever for the duration of the entire trial and was observed using predominately the right hand and arm for most activities during trial with little aid of the left extremity. Therefore, the Arbitrator concludes that Petitioner's right upper extremity conditions are a sequela of his original work accident and therefore causally related. The Arbitrator further concludes that Petitioner is entitled to additional prospective medical treatment as recommended by Drs. Fakhouri and Mrozek. Px9, 11.

c. Hepatitis C

The Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that his Hepatitis C viral infection was the result of his June 1999 work accident or as a sequela of medical treatment rendered in connection to the accident.

Petitioner failed to present any medical evidence, note, expert opinion or otherwise that he contracted Hepatitis C through one or more alleged blood transfusions. Petitioner asserts various blood transfusions were performed as a result of his traumatic injury. In support thereof, Petitioner points to various documents purporting to show Christ Hospital ordering various blood bags for blood transfusions. However, Petitioner fails to state which blood bag or order, if any, caused him to be infected with Hepatitis C. Moreover, when pressed at trial where specifically in the record such causal evidence could be found, Petitioner was non-responsive and unclear. Interestingly, Petitioner did not address the intravenous therapy administered by paramedics during ambulance transport.

Petitioner asserted that Christ used blood units from Life Blood and ACL, who were either unlicensed or unauthorized to perform testing on such units. However, Petitioner also later asserted that Advocate Christ's Blood Bank and not Life Blood or ACL was responsible for his infection. Petitioner's conflicting positions fail to persuasively identify any entity that provided blood bags infected with Hepatitis C.

In contrast, investigations by the DHHS concluded that there were no questionable practices leading to any transfusion transmitted infection, such as Hepatitis C. Similarly, Dr. Conibear, Respondent's Section 12 examiner, noted that Petitioner's treatment records first identified the presence of elevated liver enzymes eventually found to be consistent with chronic Hepatitis C in 2007. In 2008, Petitioner first began treating for his Hepatitis C. Dr. Conibear noted that in December 2008, tests showed that Petitioner's Hepatitis C virus was gone. Rx34. Dr. Conibear concluded that there was no objective evidence to support a causal connection between Petitioner's Hepatitis C and the three units of blood he received in June 1999. The Arbitrator adopts the findings of DHHS and Dr. Conibear.

The Arbitrator also notes that while there was evidence suggesting Petitioner was at one time prior to his work accident an intravenous drug user, which Petitioner vehemently denied, the Arbitrator need not consider

this in light of the foregoing analysis. Based on the foregoing, the Arbitrator concludes that Petitioner's now resolved Hepatitis C is not causally related to his work accident and therefore all treatment related to that Hepatitis C and subsequent care is also not causally related.

d. Mental Condition(s) and Injuries

The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he suffered mental injuries as a direct result of his work accident. There is no doubt Petitioner suffered a sudden and severe emotional shock when his left hand, wrist and part of his forearm was pulled into a grinding machine, ultimately resulting in amputation. Petitioner was diagnosed with acute stress disorder and ultimately chronic post-traumatic stress disorder.

The Arbitrator assigns less weight to the opinions of Respondent's psychiatric/psychologic opinions, as those opinions ultimately relate Petitioner's mental health condition(s) on his substance abuse. In so finding, the Arbitrator notes that while it is likely Petitioner was a substance abuser before the accident, noting intravenous drug use 20 years prior as well as marijuana and alcohol use following military service, there is no doubt Petitioner's work accident led to a cascade mental health problems, which has made worse a variety of personal, physical and social problems, including a worsening of his own alcoholism. The Arbitrator's conclusions are supported by Dr. Karimi, who has opined Petitioner's condition with respect to his mental health is related to his amputation injury. Dr. Karimi also credibly explained that Petitioner will require on going mental health intervention by way of medication and therapy.

The Arbitrator rejects Dr. Lahmeyer's opinions which attributed Petitioner's mental health problems now to alcoholism. Dr. Lahmeyer, however, ultimately admitted and acknowledged that it was "clear that after his amputation he began to drink heavily and become pessimistic about ever working again." It is well settled that causation may be shown where the accident was causative factor. Here, there is evidence that Petitioner's accident was at least a causative factor if not the cause of Petitioner's severe mental health conditions and there is further persuasive evidence in the record to suggest that such conditions have not reached maximum medical improvement and continue to require ongoing care and treatment. Respondent shall authorize and approve the ongoing mental health treatment recommendations of Dr. Karimi.

e. Left Upper Extremity/Shoulder

The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that his left shoulder condition is causally related to his work accident. Records demonstrate that Petitioner first began receiving therapy to the left shoulder as early as August and October 1999. In December 1999, therapists noted *worsening* left shoulder pain, indicating to the Arbitrator that Petitioner had in fact, as he claimed, been experiencing left shoulder pain after the accident. (Emphasis added). This further suggests that Petitioner had voiced those complaints to his therapists in August and October 1999. The Arbitrator assigns lesser weight to the medical opinions offered by Dr. Long, who concluded Petitioner injured the left shoulder in January 2000 but admitted he could not prove it. Dr. Long's conclusion that Petitioner was pain free is also entitled to lesser weight, as Dr. Long improperly characterized the medical record, which by inference was referring to significantly reduced pain the area of the stump, which had recently undergone excision and revision. The Arbitrator also rejects the conclusions of Dr. Wolin, who believed Petitioner's shoulder pain was related to the period of immobilization that he underwent subsequent to the surgeries on his left forearm amputation. Not only was there no period of immobilization in any medical record noted but even if there were, Petitioner's left shoulder pain from immobilization would still be causally related as a sequela or consequence of his original work injuries. Further, Dr. Wolin's suggestion of capsulitis, while supported by Dr. Fakhouri's noted frozen

shoulder, was not adequately explained as to its cause or whether it had improved with therapy. Finally, Dr. Wolin failed to adequately and persuasively explain why Petitioner's rotator cuff tear was not caused by or related to the mechanism of the work accident, to the capsulitis and/or any period of alleged immobilization. In this regard, Dr. Fakhouri's opinions were not entirely rebutted.

Dr. Fakhouri's opinion, to which the Arbitrator places greater weight, persuasively opined that Petitioner's left shoulder conditions was the result of his arm being pulled into the grinding machine at the time of the work accident. Dr. Fakhouri also noted Petitioner had no prior problems with the left shoulder before the work accident. Dr. Fakhouri's records document ongoing but failed conservative care for the left shoulder and worsening of the left shoulder with use of the left hand prosthesis. Petitioner's left shoulder was eventually treated surgically and Petitioner was released from care. The Arbitrator does not find anything in the medical record at this time to suggest Petitioner is in need of any left shoulder medical treatment. Therefore, the Arbitrator concludes Petitioner's left shoulder condition(s) is causally related to his work accident.

f. Lumbar Spine/Low Back

The Arbitrator concludes that Petitioner failed to prove that his lumbar spine/low back condition(s) were caused by or the result of his original work accident of June 18, 1999. In so finding, the Arbitrator notes a delayed onset or reporting of low back complaints and a lack of any persuasive medical opinion finding causation between Petitioner's work accident and any lumbar spine/low back condition. The Arbitrator notes that at the April 1, 2008 visit with Dr. Chang, Petitioner related long-standing history of lower back pain radiating into the right groin and that he did not recall any specific event or injury to initiate the pain. While the Arbitrator acknowledges Dr. Bernstein's opinions on this matter, the Arbitrator need not rely on same in light of the above findings and conclusions but nevertheless assigns weight to this opinion.

g. Cervical Spine/Neck

The Arbitrator concludes that Petitioner failed to prove that his cervical spine/neck condition(s) were caused by or the result of his original work accident of June 18, 1999. In so finding, the Arbitrator again notes the delayed onset of symptoms and delayed reporting of such symptoms. There is also a lack of any persuasive medical opinion causally relating any cervical spine/neck issues to the 1999 work accident. While the Arbitrator acknowledges Dr. Bernstein's opinions on this matter, the Arbitrator need not rely on same in light of the above findings and conclusions but nevertheless assigns weight to this opinion.

ISSUE (G) ***What were Petitioner's earnings?***
ISSUE (N) ***Is Respondent due any credit?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, the parties disputed the issue of earnings. Ax1. Petitioner alleged he worked 96 hours but failed to state what his average weekly wage or earnings in the year preceding his accident were. Ax1. Respondent asserted that the average weekly wage was $378.73. The Arbitrator finds and concludes that Petitioner failed to prove his alleged earnings, having produced no evidence as to hourly earnings, paychecks or that he worked 96 hours per week or that overtime was mandatory. The Arbitrator also notes that while Petitioner testified he was underpaid TTD based on his asserted average weekly wage, any underpayment claim is waived as Petitioner failed to indicate same on the request for hearing form. Ax1. Respondent's unrebutted evidence suggested that Petitioner was paid biweekly and on average earned $378.73 per week. Rx29-30. Therefore, the Arbitrator concludes that Petitioner's average weekly wage was $378.73 per week and thus his earnings in the year preceding his injury were $19,693.96. The Arbitrator further concludes that Respondent is

entitled to a TTD credit of $269,351.31 based upon payments made to Petitioner since the date of the work accident. Rx29-30. Petitioner failed to present any evidence to contradict this figure or that he has received TTD ongoing and through the date of Arbitration.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, the parties disputed the issue of medical liability. The Arbitrator concludes that Respondent has not yet paid for all reasonable and necessary medical expenses. In so finding, the Arbitrator notes that Petitioner submitted various alleged outstanding medical bills, out-of-pocket expenses and incurred costs associated with his work accident. Px20. The Arbitrator addresses each of the identified alleged outstanding costs as follows:

Regarding the alleged out-of-pocket expenses for Office Depot OfficeMax, the Arbitrator denies such expenses as they were neither explained nor substantiated at trial. Regarding the out-of-pocket expenses for Tinley Park pharmacy and Walmart medication, the Arbitrator denies same as they are not explained or substantiated.

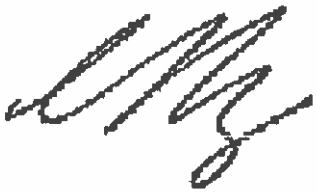
Regarding the alleged out-of-pocket expenses for transportation, the Arbitrator also denies same as they are also not substantiated nor were they explained at trial as to what they were related to.

Regarding the outstanding balance due with Dr. Karimi for dates of service April 28, 2012 through March 17, 2016, the Arbitrator awards $2,601.90 as such charges are causally related to Petitioner's work related mental health condition(s) for which he continues to treat with Dr. Karimi. Against this specific award, Respondent shall be given a credit of for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit.

Regarding Wellness blood test panel, the Arbitrator denies same, having found that Petitioner's Hepatitis C condition is not related to the work accident in question. Moreover no explanation or evidence was provided in connection with the panel performed on July 12, 2016. The Arbitrator further denies be July 20, 2016 $70.00 payment to Dr. Anthony as it is neither substantiated by any medical record nor was the out of pocket expense explained. Regarding the prescription from Osco drug, the Arbitrator finds that such prescriptions are removed given that there are no outstanding balances alleged to have been incurred as out-of-pocket expenses.

Regarding the March 25, 2016, April 21, 2016, May 19, 2016 and August 11, 2016 out-of-pocket expenses for prescription medications issued by Dr. Elizabeth Kurnat, the Arbitrator denies these out-of-pocket expenses to Petitioner as Dr. Kurnat's records were not submitted into evidence nor is there anything in the record to suggest these expenses are related to the work accident treatment.

Regarding the July 14, 2016 out-of-pocket expenses totaling $205.00 incurred at Tinley Park Pharmacy for prescriptions issued by Dr. Karimi, which include sertraline, bupropion, lorazepam, risperidone, vitamin D, the Arbitrator awards these out-of-pocket expenses directly to Petitioner as they are causally related to Petitioner's work-related psychiatric and psychological trauma.



Signature of Arbitrator

12-29-2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juan C. Hippolito,

Petitioner,

vs. NO: 11 WC 44490

Dezurik Apco Valve & Primer,

Respondent.

18IWCC0458

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, 3rd choice of doctor, prospective medical care, and penalties & attorney fees, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- This case was subject to a prior §19(b) hearing, Commission Review, and Appeal to the Circuit Court. The Circuit Court remanded the matter back to the Commission, which remanded it back to the Arbitrator. The case again was heard under another §19(b), wherein, the Decision of Arbitrator Kane, (corrected) filed on December 1, 2017, found that Petitioner sustained accidental injuries arising out of and in the course of his

employment with Respondent on February 22, 2011 (stipulated accident-prior determination). The Arbitrator further found that Petitioner's current condition of ill-being was not causally related to the accident. The Arbitrator found the opinion of Dr. Candido persuasive and concluded that Petitioner reached maximum medical improvement (MMI) as of July 22, 2014 and was in need of no further care. The Arbitrator found that Petitioner was entitled to an award of 5 weeks of temporary total disability benefits [(prior determination) (February 23, 2011-March 8, 2011 & March 22, 2011-April 11, 2011)] at a rate of $314.87 per week under §8(b) of the Act ($1.574.35 total TTD). The Arbitrator found that Petitioner is not entitled to an award of expenses and prospective care as Petitioner was determined to be at MMI for reasonable and necessary medical expenses under §8(a) of the Act. Petitioner filed for Review of the Decision of Arbitrator Kane

- Background from prior§19(b) hearing.
Petitioner testified he was a 40-year-old employee of Respondent, who described his job as a laborer. On the date of accident, February 22, 2011, at about 9:00am (he started that day at 7:00am), Petitioner testified that he was working cleaning pieces that could be painted. Petitioner stated that when he was working with a piece he turned the piece around to clean it on the other side and the piece got stuck on the skid. Petitioner stated that to try to get the piece unstuck he lifted up the piece and that was when he fell and was injured. Petitioner stated that it was a metal, iron piece. He injured his lower back then. Petitioner indicated from the time he started working until that incident he did not have any back problems. Petitioner did not finish work that day as they took him to Northwest Community Hospital and then sent Petitioner home. Petitioner began treating with Dr. Patel at the hospital from February 22, 2011 through March 8, 2011 and during that time Petitioner was on light duty restrictions. On March 8, 2011 Petitioner was sent back to work with no restrictions. Petitioner returned to Dr. Patel March 22, 2011; he stated that when he returned to work at his regular job he worked and finished the day and ended up having a lot of pain. Petitioner stated that the problem was when he woke up, he could not move out of bed. On March 22, 2011 Dr. Patel referred Petitioner for physical therapy and put Petitioner back on light duty. Petitioner had the therapy at Northwest Community Hospital from March 25, 2011 through April 20, 2011. After therapy Petitioner saw Dr. Thota at Northwest Community Hospital on May 6, 2011. Dr. Thota referred Petitioner for an MRI. Petitioner returned to Northwest Community Hospital after the MRI and was kept on light duty restrictions. Petitioner did not recall if he returned to light duty prior to the MRI. Petitioner stated that he may have worked light duty April 12, 2011 until 2012. Petitioner indicated they had taken him from "the area they cleaned the parts and put him into another machine that cleans the parts." Petitioner testified that he had to do the same job activities; however, on the first machine he had to bend his back. Petitioner stated on the machine he was moved to he just had to be stand up and put his hands inside the machine as he was working with smaller parts.

- Petitioner recalled being sent to Dr. Bernstein October 10, 2011. He recalled not seeing a doctor for about five months in 2011; Respondent did not send him to see any doctor; he was working during that time at the machine with the smaller parts of metal/iron. Petitioner returned to see Dr. Patel (his doctor) in October 2011. Petitioner recalled seeing Dr. Mark Lorenz in January 2012. Dr. Lorenz referred Petitioner for another MRI for his back and prescribed medication. Petitioner saw Dr. Lorenz several times in 2012, the last being about August 8, 2012. Petitioner saw Mr. Pittman February 4, 2013 at Dr. Lorenz office and was then referred for pain management where Petitioner had two injections by the pain management doctor. Petitioner indicated one injection helped him for that day and the other lasted for two to three days; he was not sure how long he had the relief. Petitioner recalled the last time he saw the pain doctor was October 7, 2013. Petitioner then started seeing a different doctor, Dr. Patel at Elgin Medical & Dental Center in February 2014. Petitioner was then referred for a neurosurgical evaluation in January 2015. Petitioner saw Dr. Matthew Ross March 11, 2015 who recommended a discogram. Petitioner stated that he wanted the discogram as he needed to get relief from the pain.

- Petitioner testified that he feels the pain in his lower back, his legs, and down to his feet. He stated he also feels a burning under his butt and sometimes, not very often, his legs and butt get shaky and he gets numbness in his legs from his butt down to his feet. Petitioner is still taking medication prescribed by Dr. Patel. Petitioner was working until October 24, 2014. Petitioner stated that he stopped working October 25, 2014. Petitioner stated that he could not do the job duty they told him to do with his restrictions. Petitioner testified that Respondent stopped him from working with the restrictions. Petitioner stated that he told Respondent it was hurting a lot and the supervisor and a guy from human resources told Petitioner to go to the doctor. Petitioner stated he did not have insurance. Petitioner stated he went to Dr. Patel and Respondent said they did not have any more work for Petitioner with the restrictions. Petitioner stated that the restrictions were no bending or twisting. Petitioner testified that he had not worked anywhere since October 25, 2014 and other than Dr. Patel or Dr. Ross, Petitioner had not seen any other doctors since October 25, 2014. Petitioner testified that he had no injuries or accidents prior to February 22, 2011 and he stated he had no new accidents or injuries since he stopped working.

- Testimony from current §19(b) hearing.
  Petitioner agreed he had an accident at Respondent February 22, 2011 at about 9:00am. Petitioner stated that morning he was cleaning iron pieces to be painted and while he was working with a piece he turned it around to clean it on the other side and the piece got stuck in the skid and he tried to get it unstuck and he lifted the piece and that was when he fell and was injured in his lower back (at that time). Petitioner started working for Respondent August 23, 2010 and from then until the accident he had no back problems. Petitioner did not finish his shift that day as they took him to Northwest Community Hospital and then sent him home. Petitioner began treating there with Dr. Patel and

treated with Dr. Patel from February 22, 2011 through March 8, 2011; during that time, he was on light duty restrictions. On March 8, 2011 he returned to work with no restrictions. Petitioner stated that when he returned to his regular job, he ended the day in a lot of pain. He stated when he woke the next morning he could not move out of bed. On March 22, 2011 he returned to see Dr. Patel. The doctor sent Petitioner for physical therapy and he was placed back on light duty. Petitioner had therapy at Northwest Community Hospital from March 25 through April 20, 2011. After therapy, Petitioner saw Dr. Thota at Northwest Community Hospital on May 6, 2011. The doctor sent Petitioner for an MRI of his back. Petitioner returned after the MRI and was kept on light duty restrictions. Petitioner did not recall if he returned to light work at that time (It was indicated he returned to light duty April 12, 2011 through 2012). Petitioner stated that he had been taken out of his clean parts area and put on another machine that cleaned metal parts. The other machine did not require Petitioner to bend his back, he just stood and put his hands inside the machine as the parts he was cleaning were smaller metal parts.

- Petitioner recalled seeing a Dr. Bernstein on October 10, 2011. He then did not see a doctor for about 5 months, while he was working the lighter job. Petitioner had seen Dr. Patel in October 2011 and then Dr. Lorenz January 2012. Dr. Lorenz referred Petitioner for another MRI of his back. After the MRI, Dr. Lorenz prescribed medication. Petitioner saw Dr. Lorenz several times through 2012 and last saw him August 8, 2012. Petitioner saw Dr. Pittman at Dr. Lorenz' office February 4, 2013 and was then referred for pain management. Petitioner underwent several injections by Dr. Gupta. Petitioner stated that the injections had helped the pain at the time for 1-3 days. The last time he saw the pain doctor was October 7, 2013. Petitioner then saw a different Dr. Patel at Elgin Medical & Dental Center about May 2014 and that doctor referred Petitioner for a neurosurgical evaluation in January 2015. Petitioner saw Dr. Matthew Ross on March 11, 2015. Dr. Ross recommended a discogram. Petitioner stated he wanted the test so he could get relief from the pain. Petitioner testified that he still felt the pain in his lower back, into his legs and to his feet. Petitioner stated he also has a burning feeling in his buttocks and sometimes his legs and buttocks get shaky. Petitioner was still taking medication prescribed by Dr. Patel.

- Petitioner agreed that he continued working until October 24, 2014, when Respondent stopped giving him restricted work. He stated he could not do the job duties they told him to do, he told the supervisor and the HR person about the pain. Petitioner stated Respondent told Petitioner to go to the doctor, but he did not have insurance. Petitioner returned to see Dr. Patel and when he returned to Respondent they would not give him the restricted work as he could not bend or twist with the restrictions. Petitioner had not worked anywhere since that time. Petitioner had not seen any other doctors besides Dr. Patel or Dr. Ross since October 25, 2014. Petitioner denied having any accidents before February 22, 2011 and since he stopped working in October of 2014 he had no other accidents or injuries involving his low back.

- For this Review, Petitioner argued that the evidence clearly established that Petitioner's present condition of ill-being is causally related to his accidental injury February 22, 2011. Petitioner stated that the Arbitrator noted Petitioner was at MMI July 22, 2014 and then could return to medium work, so his condition was no longer causally related. Petitioner stated that the Arbitrator based the decision as to 'several large breaks' in treatment and referring to Petitioner's complaint characteristics changing radically May 2011 through October 2011. Petitioner stated the Arbitrator noted Dr. Lorenz discharged Petitioner multiple times and despite having access to multiple physicians Petitioner did not seek care until November 2013 and did not mention neck pain until December 14. Petitioner argued that Dr. Lorenz recommended surgery and permanent restrictions and did not discharge Petitioner. Petitioner indicated it was irrelevant discussing MMI in relation to his current condition of ill-being. Petitioner argued nothing in Dr. Lorenz or Dr. Candido's (IME) report identified any changes in Petitioner's condition of ill-being being broken or an intervening event breaking the causal chain of events on July 22, 2014. Petitioner stated the evidence showed Petitioner suffered a low back injury February 22, 2011 that caused a herniated disc and annular tear that required surgical intervention and that Petitioner had no prior symptoms. Petitioner indicated Respondent's examiner, Dr. Candido, felt the pain had remained constant since the initial injury. Petitioner requests the Commission reverse to find his current condition causally related to the injury. Petitioner requests the Commission modify to find an ongoing causal connection and award temporary total disability (TTD), medical expenses, prospective medical care, and penalties and attorney fees.

- For this Review, Respondent stated that the Commission should find that Petitioner suffered an intervening work injury on November 7, 2013, which superseded his original injury and all benefits after that should be denied. Respondent stated that if the Commission does not find Petitioner suffered an intervening injury, the Commission should affirm the decision of the Arbitrator that, based on Dr. Candido's report, Petitioner had reached MMI on July 23, 2014 and his current condition is not causally related to the February 22, 2011 work accident. Respondent stated that the Commission should affirm the decision of the Arbitrator that Petitioner is not entitled to any further TTD benefits or prospective medical care. Respondent stated that the Commission should affirm the decision of the Arbitrator finding that Respondent has paid all reasonable and necessary medical expenses. Respondent stated the Commission should affirm the decision finding that Petitioner is not entitled to penalties or attorney fees. Respondent requests the Commission affirm the decision of the Arbitrator that Petitioner reached MMI as of 7/22/14 and his current condition of ill-being is not causally related to the work injury so Petitioner is not entitled to further TTD, medical expenses, prospective medical care, or penalties and attorney fees.

The Commission finds that there is no indication of any prior low back condition or treatment. Petitioner clearly suffered an injury at work and as a result, he was on permanent restrictions and did not want to proceed with surgical intervention at that time. Petitioner has the records documenting his ongoing complaints since the accident but had not been under continuous medical care since this accident of February 2011. Prior records indicated Petitioner had a minor slip and fall injury onto his back November 7, 2013. Respondent's examiner indicated Petitioner said that the accident involved his neck and upper back, rather than his lower back. It is not clear what, if any, medical care was rendered after the November 7, 2013 injury other than the indication in records of Petitioner going to the emergency room (ER) later that day and then Dr. Patel at Elgin Medical & Dental Center about May 2014, who then referred Petitioner for a neurosurgical evaluation where Petitioner saw Dr. Matthew Ross March 11, 2015. Dr. Ross recommended a discogram. Petitioner was previously declared at MMI as to surgical intervention (Petitioner did not want surgery). The subsequent slip and fall may have aggravated Petitioner's back condition; though it can be argued that this broke the chain of causal relationship, the argument is not supported by the record.

The Arbitrator found the date of MMI as the date of Dr. Candido's July 22, 2014 IME, which is not supported by the medical records in evidence, with Petitioner's permanent restrictions and prior surgical recommendation by his treating doctors. The evidence and testimony demonstrates that Petitioner met his burden of proving an ongoing causal relationship to his current condition of ill-being. The Commission, finds the decision of the Arbitrator contrary to the weight of the evidence, and, herein, reverses the Arbitrator's finding as to causal connection to find Petitioner's current condition of ill-being causally related to the accident of February 22, 2011.

The Commission, with the above finding of an ongoing causal connection to Petitioner's condition of ill-being finds Petitioner met his burden of proving entitlement to additional TTD benefits. Petitioner remains on restrictions and because Respondent apparently is no longer willing or able to accommodate the restrictions, further benefits are in order. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein reverses/modifies the Arbitrator's findings. The Commission finds that the evidence clearly established Petitioner's condition has not yet stabilized and Petitioner is entitled to TTD beyond April 11, 2011. The Commission, herein, awards total TTD benefits of 30-4/7 weeks (initial period awarded plus October 25, 2014 to April 21, 2015).

The Commission, with the above finding of an ongoing causal connection to Petitioner's condition of ill-being finds Petitioner met his burden of proving entitlement to an award of additional medical expenses/prospective medical care benefits. Petitioner remains on restrictions and in need of further care. Petitioner wants to proceed with further care and surgery had been previously recommended. The Commission notes that the issue on Review regarding 3rd choice of physician was not addressed by either party and is hereby considered as waived. The

Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein, reverses/modifies the decision of the Arbitrator. The Commission orders Respondent to authorize and pay for the recommended treatment including the discogram, recommended surgery, and further care and treatment of his causally related condition of ill-being.

The Commission, with the above finding of ongoing causal connection, even though that warrants further benefits, finds that there is clear reason supported in the records for Respondent to have reasonably relied on Dr. Candido's opinions in denying further liability. The Commission finds that Respondent did not act in an unreasonable or vexatious manner that would otherwise warrant penalties and attorney fees. Petitioner failed to meet his burden of proving entitlement to any penalties and attorney fees. Petitioner failed to establish that Respondent acted in unreasonable and vexatious behavior to warrant any such penalties/attorney fees. 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 a denial of penalties and attorney fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $314.87 per week for a period of 30-4/7 weeks, that being the further period of temporary total incapacity for work under §8(b), and that as provided in §8(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for the prospective medical testing and surgery, and related care recommended, under §8(a) of the Act.

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

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

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

18IWCC0458

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $60,000.00. 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: JUL 23 2018
o-5/24/18
DLG/jsf
045

David Gore

Michael J. Brennan

Deborah Simpson

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

HIPOLITO, JUAN
Employee/Petitioner

Case# **11WC044490**

DEZURIK APCO VALVE & PRIMER INC
Employer/Respondent

18IWCC0458

On 12/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.43% 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:

5317 JOHN J CASTANEDA
514 W STATE
SUITE 210
GENEVA, IL 60134

0210 GANAN & SHAPIRO PC
JULIE M SCHUM
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
CORRECTED
ARBITRATION DECISION
19(b)

Juan Hipolito
Employee/Petitioner

v.

Dezurik Apco Valve & Primer Inc.
Employer/Respondent

Case # 11 WC 44490

Consolidated cases: _____

18IWCC0458

An *Application for Adjustment 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 and David A. Kane** Arbitrators of the Commission, in the city of **Chicago** , on **4/21/15** and **10/24/17.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$24560.12**; the average weekly wage was **$472.31**.

On the date of accident, Petitioner was **39** years of age, *single* with **1** dependent children.

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

Respondent shall be given a credit of **$1594.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1594.20**.

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

ORDER

The Arbitrator finds the opinion of Dr. Candido persuasive and concludes that Petitioner reached maximum medical improvement as of July 22, 2014 and is in need of no further care.

The Arbitrator concludes that Petitioner was entitled to TTD benefits from February 23, 2011-March 8, 2011 and March 22, 2011 through April 11, 2011. The Respondent is given credit for $1,594.20.

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

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

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

David A. Kane
Signature of Arbitrator

December 1, 2017
Date

ICArbDec19(b)

DEC 1 - 2017

Juan Hipolito v. Dezurik Apco Valve & Primer, Inc.

11 WC 44490

Procedural History

This matter came to hearing before Arbitrator Williams on Petitioner's motion for benefits under Section 19(b) of the Act. He issued his decision on this matter on May 7, 2015. He found that Petitioner suffered from an intervening accident on November 7, 2013, that rendered all other issues moot by breaking the causal connection chain.

Petitioner filed a review of this matter. The Commission affirmed on November 24, 2015. Petitioner then reviewed the matter to the Circuit Court of Cook County.

The Circuit Court struck the finding of intervening accident and remanded the matter to the Commission for further findings on October 13, 2016. The Commission remanded it to the Arbitrator for further findings in conjunction with the decision of the Circuit Court on May 17, 2017. It has since been assigned to Arbitrator Kane as Arbitrator Williams is no longer sitting.

Findings of Fact

Juan Hipolito (hereinafter "Petitioner") was employed by Dezurik Apco Valve & Primer, Inc (hereinafter "Respondent") on February 22, 2011, as a laborer. He testified that his duties involved sorting and working with machine parts and that, on February 22, 2011, he felt pain in his lower back while trying to dislodge parts from a skid. The incident is not disputed.

Petitioner was seen at Northwest Community Hospital that day by Dr. Newman. He gave a consistent history of accident and was diagnosed with a lower back pain for which medication and light duty were prescribed. Petitioner testified that light duty restrictions through this time were accommodated.

Dr. Newman continued to treat Petitioner throughout March 2011. He was discharged on March 8, 2011 with minimal pain to full duty work. On March 22, 2011, he returned to Dr. Newman indicating the while cleaning some parts the day before, he felt a sudden pinch in his back and the pain got worse. Dr. Newman once again diagnosed a back sprain for which he recommended physical therapy, medication and light duty.

By his April 15, 2011 follow up, Petitioner reported significant improvement. By that time, he was no longer taking any medication. He was discharged to return to full duty work at that time.

On May 6, 2011, Petitioner returned reporting that now he had sharp pain radiating down his left buttock. There is no mention of his work activities or any additional incidents at that time. He was diagnosed with low back pain with radiculopathy for which medication, an MRI and light duty work were recommended.

The MRI was performed on May 13, 2011. It was interpreted to show mild broad based annular bulging at L4-5 and L5-S1. It was noted there ~~was an annular fissure at L5-S1. He was subsequently diagnose with~~ sacroiliitis bilaterally and bulging discs from L4-S1 for which he was referred to Dr. Levin for an injection. Based upon the medical submitted

into evidence, Petitioner never sought care from Dr. Levin nor does he seek care for any other physicians until October 2011.

Petitioner does not return to Northwest Community Hospital until October 20, 2011. At that point, he reported that now the back pain traveled down his left leg. Petitioner saw Dr. Patel the following day. There is no referral to Dr. Patel in the records. Petitioner reported a low back strain on February 22, 2011 and noted that the day prior, he was in too much pain to get out of bed. Dr. Patel diagnosed chronic back pain for which he recommended a second orthopedic opinion. It should be noted that his notes reflect that Petitioner was seen by Dr. Bernstein who opined his condition was not surgical. Petitioner did not submit Dr. Bernstein's records into evidence. It should also be noted that a number of the records included in Petitioner's exhibit 4, from Premier Pain Specialists, include a number of records for a patient named Martin Keen.

On January 5, 2012, Petitioner was seen by Dr. Lorenz. He gave a consistent history of accident regarding the February 22, 2011 incident and then reported that he had an increase of back pain in October while lifting at work. Dr. Lorenz noted that Petitioner said he did not report the second incident to his employer. Dr. Lorenz diagnosed internal disc disruption apparently L5-S1 with possible disc herniation. He recommended a repeat MRI and medication.

A repeat MRI of the lumbar spine was performed on January 16, 2012. It was interpreted to show disc space narrowing with desiccation and a shallow disc protrusion as L4-5 and disc space narrowing with desiccation and a left para-central annular tear at L5-S1.

Petitioner returned to Dr. Lorenz on February 8, 2012. Dr. Lorenz recommended a FCE and medication. His complaints continued at his March 12, 2012 and April 4, 2012. The FCE was never performed. Dr. Lorenz opined that Petitioner was a surgical candidate, not for any specific pathology, but because he'd failed conservative care. Barring surgery, Dr. Lorenz felt Petitioner was at MMI.

On May 24, 2012, Petitioner continued to complain of pain and requested a second opinion. Dr. Lorenz noted Petitioner was to return on a prn basis.

On February 4, 2013, Petitioner returned with complaints of back pain. His diagnosis L4-5, L5-S1 spondylosis with lumbar disc herniation and axial back pain. Dr. Lorenz discharged him at that time with a permanent 10 pound lifting restriction. Based on Petitioner's testimony, Respondent continued to accommodate at that time.

On June 3, 2013, Petitioner was seen by Dr. Dasgupta. There is no indication that Petitioner was referred to him by any other physician. Petitioner reported a consistent history of accident on February 22, 2011. He complained of constant sharp pain in his back with numbness in both legs. He was diagnosed with lumbar radiculitis due to bilateral S1 nerve root abutment by disc herniation at L5-S1. He recommended an ESI and medication.

~~The injection was performed on August 6, 2013, and Petitioner~~ reported 50% improvement at his follow up visit. A second injection was performed on September 9, 2013. Though Petitioner allegedly reported

improvement, his pain rating remained at 9/10 at his October 7, 2013 follow up. Petitioner never returned to Dr. Dasgupta.

On February 20, 2014, Petitioner saw Dr. Patel. His primary complaint was irritated throat and phlem. It was noted that he had back pain from a work injury on February 20, 2011 with a second injury on November 7, 2013. He was diagnosed with acute pharyngitis and chronic back pain.

A MRI of the cervical spine was performed on April 4, 2014. It was interpreted to show minimal disc bulging at C3-4, mild disc bulge at C4-5, and a mild broad disc bulge with encroachment at C5-6. The impression indicates only mild degenerative changes with no cord compression or lesion.

Petitioner followed up with Dr. Patel on May 13, 2014. Petitioner reported back pain for which he was requesting medication. No diagnosis or treatment plan is noted and there is no indication from Dr. Patel's record that he saw or examined Petitioner in any way on that date.

On June 5, 2014, Dr. Patel evaluated Petitioner for back pain. He reported an accident at work three years prior but no further description is found in the records. There are no complaints of neck pain at all and it is checked off with no indication of problems in the examination portion of the report.

On June 19, 2014, Petitioner saw Dr. Patel in follow up for the MRI. No complaints are noted other than dry throat and there's no evidence in the medical records that Dr. Patel examined Petitioner in any way on that date.

Petitioner returned to Dr. Patel on July 18, 2014 in follow up. No complaints are noted and there's no evidence in the medical records that Dr. Patel examined Petitioner in any way on that date.

On October 25, 2014, Dr. Patel notes that Petitioner requested work restrictions of no bending, squatting or kneeling. There is no indication in the records that Dr. Patel examined Petitioner in any way on that date and the examination portion of his notes is entirely blank.

On December 19, 2014, Dr. Patel notes that Petitioner was seen for left ear problems. He also complained that his back and neck still hurts. There is no evidence in the records that Dr. Patel performed an examination of Petitioner at all on that date.

Dr. Patel saw Petitioner again on January 27, 2015. Petitioner requested a referral to a neurosurgeon. There is no evidence in the records that Dr. Patel examined Petitioner in any way on that date.

Petitioner was seen by Dr. Ross on March 11, 2015, for a second opinion. He gave a consistent history of the initial incident and reported a second incident while lifting something at work on November 7, 2013. Petitioner reporting falling during that incident and complained of neck pain following the same. On examination, Petitioner had full range of motion in his neck and was able to bend to 45 degrees before being limited by reported pain. Dr. Ross reviewed the MRI's and opined that Petitioner required a discogram to determine if he was a candidate for a fusion.

On July 22, 2014, Petitioner was evaluated by Dr. Candido. On examination, Dr. Candido found positive Faber's tests on both sides with a positive straight leg raise. He found multiple positive Waddell's signs

including reports of superficial and diffuse non anatomic tenderness as well as complaints of pain with axial loading. Dr. Candido also noted that when done with distraction, the straight leg raise was not painful in the legs and the alleged pain was not in a sciatic nerve distribution. Petitioner also reported hypesthesia in a branch of the nerve associated with L2-3 and not any disc with pathology. Petitioner also demonstrated facial grimacing while performing simple movements inconsistent with the posture he assumed during the exam.

Dr. Candido noted that the MRI contemporaneous to his accident did not demonstrate any surgical pathology or pathology that could contribute to an evolving radiculopathy. He felt that Petitioner was capable of working at a medium duty level as permanent restrictions and that he was at MMI with no further need for care.

Conclusions of Law

The aforementioned findings of fact are hereby incorporated into every section of the conclusions of law.

With regards to "F", is Petitioner's current condition causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds the opinion of Dr. Candido persuasive and concludes that Petitioner was at maximum medical improvement as of July 22, 2014 and could return to work with medium duty restrictions. Therefore, Petitioner's current condition is no longer causally related to the work injury.

In making this finding, the Arbitrator notes that Petitioner had several large breaks in care during the course of his treatment. Based upon the records provided, Petitioner had no treatment from May 13, 2011 until October 20, 2011. At that point, Petitioner told his treating physician that the day prior, he had been in too much pain to get out of bed. There's no mention in those records that Petitioner suffered from any additional injury at work.

Petitioner tells Dr. Lorenz, three months later, of an additional incident at work but specifically denies reporting such an incident. There's also no evidence that Dr. Lorenz is given any of the prior treatment records. Dr. Lorenz also discharged Petitioner in May of 2012. He does not return to any treater until February 4, 2013. At that time, he complains only of back pain. Dr. Lorenz again discharged him.

Petitioner goes to a third physician, Dr. Dasgupta on June 3, 2013. There is no indication in any of the records that Petitioner was referred either to Dr. Lorenz or Dr. Dasgupta. Dr. Patel referred Petitioner to an orthopedic and references in his records that referral was filled by a visit to Dr. Bernstein. There is no record of a referral to Dr. Lorenz. Petitioner is first seen by Dr. Newman. Then chooses to treat with Dr. Patel. As there is no referral, Dr. Dasgupta is Petitioner's third choice. By the time Petitioner sees Dr. Dasgupta in June 2013, his complaints have expanded to include bilateral numbness. Petitioner sees Dr. Dasgupta through October 2013 and then fails to return to him for any further care.

In early 2014, Petitioner returns to Dr. Patel. However, subsequent to the February 20, 2014, there is no indication in the medical records that Dr.

Patel examined Petitioner in any way. There is no indication of any reports of neck pain at the February 20, 2014 visit and yet a cervical MRI is ordered. There are in fact no complaints of neck pain until December 19, 2014. It should also be noted that at Petitioner's June and July 2014 follow ups, no complaints are noted by the doctor nor is there any examination of Petitioner recorded.

On October 25, 2014, at Petitioner's request, Dr. Patel issues work restrictions of no bending, squatting or kneeling. There are no complaints included in those notes and there is no indication that Dr. Patel examined Petitioner in any way or that there was any change in Petitioner's condition or capabilities to merit the additional restrictions from a medical perspective.

Petitioner was evaluated by Dr. Candido, a pain management physician, on July 22, 2014. At that point, in addition to the numerous inconsistencies in the past medical records, Dr. Candido finds multiple positive Waddell's signs and a number of non anatomic complaints of pain. Dr. Candido concluded that the MRI's did not support any surgical pathology or pathology that could contribute to an evolving radiculopathy. He concluded Petitioner was at MMI and could return to medium duty work.

The Arbitrator finds Dr. Candido's opinion to be the most persuasive. The Arbitrator notes that Petitioner's complaints change radically from May 2011 to October 2011. The Arbitrator finds it significant that at the October 2011 visit, there is no mention of any work activities contributing to the increase in pain. The Arbitrator also notes that Dr. Lorenz discharges Petitioner multiple times in 2012 and 2013, finding him at maximum

medical improvement. When Petitioner returns to the care of yet another physician in June of 2013, his symptoms now include bilateral leg numbness - which had never been reported to any of the prior physicians. He stops treating with that doctor in October 2013 and doesn't return to care until February 2014, despite an alleged second injury in November of 2013.

The arbitrator notes that, despite clearly having access to multiple physicians, Petitioner did not seek any care in November of 2013 and his primary complaint at his February 20, 2014 visit was for an irritated throat and phlem. No mention is made of any neck pain at that visit.

Though Petitioner continues to treat with Dr. Patel during 2014, there is no indication in the bulk of Dr. Patel's notes that he examined Petitioner or did anything other than provide medication and work restrictions as requested. There is no mention of any neck pain until December 19, 2014 - nearly a year after the alleged November incident which supposedly caused the neck pain.

Given the sheer amount of inconsistencies both in histories and in the symptoms in the record, the Arbitrator finds the extremely detailed report of Dr. Candido to be most persuasive and credible and concludes that Petitioner reached MMI on July 22, 2014 and his current condition is therefore not related to the work incident.

With regards to "J", were the medical services that were provided to Petitioner reasonable and necessary, the Arbitrator finds as follows:

Based upon the above conclusions with regards to causal connection, the Arbitrator finds that Petitioner needed no further care subsequent to July 22, 2014, relative to the work incident. Additionally, the Arbitrator notes that, given that there are no referrals in the medical records, Dr. Dasgupta is Petitioner's third choice of physician. The Arbitrator therefore concludes that Respondent is not liable for all of the treatment rendered by Dr. Dasgupta as being outside of Petitioner's two choices of physicians.

The Arbitrator also finds the cervical MRI performed on April 4, 2014 is not related as there are no complaints of neck pain in any treatment record prior to that date.

With regards to "K", is Petitioner entitled to any prospective medical care, the Arbitrator concludes as follows:

Based upon the Arbitrator's conclusion above that Petitioner was at MMI as of July 22, 2014 and in need of no further care, no prospective medical benefits are awarded.

With regards to "L", is Petitioner entitled to any TTD benefits, the Arbitrator concludes as follows:

The parties have stipulated that Petitioner was entitled to TTD benefits for February 23, 2011 through March 8, 2011 and March 22, 2011 through April 11, 2011. Based upon the Arbitrator's conclusion above that Petitioner was at MMI as of July 22, 2014 and in need of no further care, no further TTD benefits are awarded.

With regards to Penalties and Fees, the Arbitrator concludes as follows:

Petitioner has filed a Petition for Penalties and fees relative to this matter. In order for Penalties and fees to be awarded under the Act, Respondent's conduct must be unreasonable and vexatious.

In the present instance, the medical records clearly show a number of breaks in Petitioner's care. They also show that Petitioner was accommodated in his light duty work for the bulk of the time he was off. The Respondent also sought the opinion of a fphysician for their IME and have rested on his conclusions. Based upon the above, the Arbitrator concludes that Respondent had reason to dispute care and deny further benefits and Respondent's conduct was not unreasonable or vexatious in nature.

In light of that, the Arbitrator declines to award any penalties or attorney's fees relative to this matter.

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)
ON REMAND FROM CIRCUIT COURT	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kristine Melody,

Petitioner,

vs. NO: 05 WC 12983

Employco n/k/a Work Place Solutions,

Respondent.

18IWCC0459

DECISION AND ORDER ON REMAND FROM THE CIRCUIT COURT

This matter had been previously heard, before Arbitrator Cronin, under §19(b)/8(a) who found accident and causal connection, and awarded benefits against Convention All as Petitioner's employer. No issue was raised by Petitioner alleging any borrowing/lending employee between Conventional All and Employco. The third-party administrator (TPA) for Employco had satisfied payment of that award. Employco n/k/a Work Place Solutions were not a named party at the time of the initial hearing. Convention All had no workers' compensation insurance and has since ceased doing business. The matter was presented on Review and the Commission affirmed the decision early 2008. Subsequent to that initial hearing and prior to a hearing on the merits, as to final disposition of the case, Petitioner amended the Application for Adjustment naming solely Employco n/k/a Work Place Solutions as party respondent (February 25, 2011) for this May 20, 2004 accident. Employco has since ceased doing business. This matter again came before Arbitrator Huebsch on Respondent's (Self Insurance Advisory Board), motion to dismiss. Arbitrator Huebsch granted the motion to dismiss and Petitioner appeals the Decision of Arbitrator filed on February 19, 2016, granting Respondent's (Self Insurance Advisory Board) motion to dismiss the case against Employco n/k/a Work Place Solutions. The matter was presented on Review and the Commission affirmed October 3, 2016. Petitioner brought the matter on appeal to the Circuit Court who remanded the matter back to the Commission. The Circuit Court confirmed the Commission decision regarding Respondent's motion to dismiss, but questioned Petitioner's ability to recover from the Injured Workers'

Benefit Fund (IWBF) and set aside the Commission decision for further proceedings against Conventional All, addressing whether Petitioner is eligible to recover from the IWBF.

The Commission notes that regardless of the issues below, there was a problem with perfecting (September 22, 2016 oral argument date) the Review here as Respondent was not even contacted to authenticate the transcript prior to the due date. At the time the Commission was preparing the matter for oral argument, the only transcript for review was received via the court reporter. Though the mainframe indicated a transcript was filed March 31, 2016, Respondent apparently did not see it to authenticate it for filing. The Commission contacted Petitioner's counsel who faxed over the authentication sheet which was then signed by Respondent August 11, 2016 and Respondent attorney noted the transcript was untimely authenticated as noted in their Statement of Exceptions. Prior to oral argument, Petitioner's counsel brought an 'original' copy of transcript (unclear how they kept the original filed copy), but again the authentication sheet indicated Respondent signed it August 11, 2016, as noted above, so Review was not properly authenticated prior to filing regardless, so the Review was not properly and timely perfected.

The Commission notes that the Arbitrator's finding of Convention All as employer in the prior §19(b)/8(a) hearing, is the law of the case on that issue, regardless if for whatever reason Employco's TPA had fulfilled payment on that award. Employco was not indicated as a party Respondent until an amended Application naming them long after that initial §19(b) hearing. The Arbitrator also noted that at the §19(b) hearing Petitioner specifically noted her employer was Convention All. Further, Petitioner was apparently aware of Employco and whatever relationship there was with Convention All prior to that §19(b) hearing and they simply did not amend the Application prior to that hearing for the Arbitrator to even consider any relationship issue there. An amended Application was filed February 25, 2011 then naming Employco for this 2004 accident. Employco had apparently since gone under therefore the Self Insurance Advisory Board was present, presenting the Motion to dismiss the now named Respondent, Employco n/k/a Work Place Solutions. The Arbitrator clearly noted the Amended Application was not timely filed and indicated the issue of employment had previously been litigated and decided in the prior hearing in 2007 so the issue of employment was a final decision which could not now be re-litigated. Regardless of the issue of properly perfecting the Review, the law of the case per the prior §19(b) hearing was that Convention All, and not Employco n/k/a Work Place Solutions, was the employer, so this matter was properly dismissed. The Arbitrator did not err in granting Respondent's motion to dismiss Employco n/k/a Work Place Solutions, and dismissing the case as Employco had been amended as the sole party Respondent. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence and herein affirms and adopts the decision dismissing the matter.

The Commission notes that Petitioner raised the issue of notice. There is no real issue as to notice to Convention All as Respondent, and as Employco had essentially represented Convention All, was also on notice, but regardless, the Arbitrator and the Commission found notice as to Convention All as the party Respondent for the §19(b) hearing in 2007, so that also

18IWCC0459

is law of the case. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence and, herein, affirms and adopts the decision.

The Commission finds, given the employer-employee findings by Arbitrator Cronin at the §19(b) hearing in 2007, that Petitioner did not file an amended Application naming Employco n/k/a Work Place Solutions until 2011. That was clearly long after the §19(b) hearing determination that Convention All was the employer and clearly beyond the statute of limitations to even re-file against Employco. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the decision.

As to addressing the Circuit Court order, the Commission finds that the IWBF cannot be pursued by Petitioner in this matter. The Commission notes that Employco was not a named party for the initial hearing that addressed who was the employer (Convention All was found as the employer now the law of the case), even though Employco's TPA apparently did satisfy that award. Petitioner opted to later amend the Application naming Employco as Respondent. The Commission notes that Employco no longer is insured (TPA) as they are no longer in business. Conventional All had no insurance, but again the Commission notes that at the time of the injury, the IWBF had not been a part of the Act (the fund did not exist) and they could not be brought in as a party Respondent due to that. The Commission further finds that the Act does not provide that the IWBF could be brought in retroactively, and again, regardless, they were not a named party to properly defend their position at the time of the initial §19(b) hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 19, 2016 is hereby affirmed and adopted. The matter is dismissed.

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.

18IWCC0459

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: JUL 23 2018
o-5/17/18
DLG/jsf
045

David Gore

Stephen Mathis

Deborah Simpson

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

Steve Heiens,

Petitioner,

vs. NO: 15WC 23018

Global Brass,

18IWCC0460

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 24, 2017, 35349is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 23 2018
o060418
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

DISSENT

I dissent from the majority's affirmance and adoption of the Arbitrator's decision and wholeheartedly disagree with the premise underlying the denial of prospective medical treatment in this claim – namely, that the recommended treatment by Dr. Gornet in the form of three-level cervical disc replacement surgery was not supported by the evidence and thus unreasonable and unnecessary. More to the point, I do not believe that such a procedure is as experimental or untested as the Arbitrator seems to think it is, nor do I believe that a guarantee of success is required in order to award such a benefit. Instead, given that even Dr. Bernardi, Respondent §12 examining physician, acknowledged not only that Petitioner's cervical condition was causally related to the accident but also that the safety profile and results are essentially the same between cervical fusions and disc replacements, I believe that the decision to proceed with such a procedure, despite its "off label" use, should ultimately rest with the Petitioner and his treating orthopedic surgeon. I also believe that there is sufficient objective medical evidence, irrespective of any radicular symptoms, to justify the surgery in question. Along these lines, I would rely on the opinion of Dr. Gornet over that of Dr. Bernardi as to the efficacy of the proposed surgery, particularly in terms of his stated goal of improving Petitioner's quality of life – which, unfortunately, may be all that Petitioner can realistically hope for at this point, but it's hope none-the-less. Therefore, I would find the procedure both reasonable and necessary and award same.

For the foregoing reasons, I respectfully dissent.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HEIENS, STEVE
Employee/Petitioner

Case# **15WC023018**

GLOBAL BRASS
Employer/Respondent

18IWCC0460

On 10/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% 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:

4620 ADWB LLC
JOHN WINTERSCHEIDT
51 EXECUTIVE PLAZA CT
MARYVILLE, IL 62082

0299 KEEFE & DePAULI PC
MICHAEL KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0460

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Steve Heiens
Employee/Petitioner

v.

Global Brass
Employer/Respondent

Case # 15 WC 23018

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 28, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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. [ ] 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

18IWCC0460

On the date of accident, **April 29, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being **in the cervical spine** *is* causally related to the accident, but Petitioner's current condition of ill-being **in the lumbar spine** *is not* causally related to the accident.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$55,631.16**; the average weekly wage was **$1,069.83**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** in non-occupational indemnity disability benefits, for a total credit of **$0.**

Respondent shall be given a credit for **all amounts paid** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

Respondent shall be given a credit in the amount of **$1,283.78** for statutory permanent partial disability already paid on the mandible fracture.

ORDER

While the Arbitrator finds that Petitioner's current condition of ill-being in the cervical spine is causally related to the accident, the Arbitrator does not find the prospective medical treatment as recommended by Dr. Gornet to be either reasonable or necessary. As such, Petitioner's request for the prospective medical treatment as recommended by Dr. Gornet for the cervical spine is hereby denied.

As Petitioner has failed to prove that his current condition of ill-being in the lumbar spine is causally related to the accident of April 29, 2015, Petitioner's request for prospective medical treatment to the lumbar spine is denied.

Respondent shall pay the reasonable and necessary medical services **as contained in Petitioner's Exhibit 11, exclusive of the October 10, 2016 lumbar MRI performed at MRI Partners of Chesterfield,** 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 Petitioner. Respondent shall pay any unpaid, related medical expenses, **exclusive of the October 10, 2016 lumbar MRI performed at MRI Partners of Chesterfield,** 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 benefits paid under its group health plan under 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.

Melinda M. Gore-Sullivan
Signature of Arbitrator

10/20/17
Date

ICArbDec19(b)

OCT 24 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Steve Heiens
Employee/Petitioner

Case # 15 WC 23018

v.

Consolidated cases: N/A

Global Brass
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is 61 years of age and has worked at Respondent Global Brass & Copper/Olin Brass since 2004. He testified that he was hired on as a maintenance tech and remains in that position. He testified that his job requires him to first troubleshoot broken or malfunctioning machines and then fix them.

Petitioner testified that he was working in his normal capacity on April 29, 2015. He testified that before that date, he had never experienced problems with his neck area. He testified that he was working near a crane when the arm of the crane came from behind him, pushing and pinning his head up against a cylinder. He testified that he was wearing a hard hat. He estimated that his head was lodged in this position for approximately 30 seconds.

Petitioner testified that when the event occurred, he felt his jaw break and he screamed. He described an immediate burning pain in his neck and upper shoulder areas. He testified that after the crane arm moved and he gathered himself, he went to the on-site medical department. He testified that he described his symptoms to the medical personnel and that a decision was made to take him to Alton Memorial Hospital.

Petitioner testified that he explained his complaints and symptoms to the emergency room personnel which also included a headache. He testified that x-rays were taken but were all found to be negative. He testified that he returned to work that but his neck and jaw complaints continued. He testified that he also discovered that he had a loose and cracked tooth and was seen by a dentist, Dr. Sclaroff. He testified that during the x-ray process, it was discovered that he had a hairline crack in his jaw. He testified that Dr. Sclaroff performed the necessary dental work.

Petitioner testified that arrangements were made for him to see Dr. Sandra Tate, who performed some injections. He testified that the injections helped for a short period of time, but that the pain returned. He testified that following his release from Dr. Tate, he was seen by his family doctor at the Illinois Healthcare Foundation in Bunker Hill. He testified that he was eventually referred to Dr. Gornet.

Petitioner testified that his neck complaints remained when he first saw Dr. Gornet. He testified that Dr. Gornet ordered additional scans and then recommended injections, which were administered by

Dr. Helen Blake. He testified that the first injection helped for a couple of weeks and that the second provided no relief at all. He testified that he likes Dr. Gornet and trusts his judgement.

Petitioner testified that after the accident, it appeared that his restless leg syndrome grew worse. He testified that he has had that condition for as long as he could remember. He further admitted that he did not know if the reason the condition was worse was because of the accident.

Petitioner testified that Dr. Gornet has offered him disc replacement surgery at C4-5, C5-6 and C6-7. He testified that he wants to have the surgery because he is tired of hurting. He acknowledges that his symptoms may not go away completely, but he believes that they will improve.

Petitioner testified that he was examined by Dr. Robert Bernardi at his employer's request on April 4, 2017. He testified that he explained the accident, his complaints and symptoms to Dr. Bernardi and that he understood that he recommends against the surgery proposed by Dr. Gornet.

Petitioner testified that his current complaints include decreased range of motion, especially when turning his head to the side. He testified that he also experiences pain when he turns his head to the side. He testified that he does not have any significant trouble looking up or looking down. He testified that he feels that the left side of his neck hurts a little bit more than his right when he turns his head to the side. He testified that activity in general is worse and that he may get a headache once or twice per week. He testified that he has no pain, numbness or tingling down his arms.

On cross-examination Petitioner agreed he continues to work without interruption and is performing his job on a daily basis. He admitted that he has not sought a medical opinion other than that of Dr. Gornet because he likes him and trusts him. He testified that he did not attempt to submit the medical treatment proposed by Dr. Gornet to his health insurance carrier.

The medical records of Olin GBC Health Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on April 29, 2015 at 10:21 a.m., at which time it was noted that he drove himself to medical and stated that he was changing a cylinder in the 8 cleaning line and that his head was pinched between the machine and crane and that he had to back the crane off to get his head out. It was noted that Petitioner complained of pain in the left cheek and jaw, that he stated his jaw was broken and that he heard a "pop" and was unable to open his mouth. Petitioner was sent to Alton Memorial Hospital. At the time of the 12:54 p.m. visit on the same date, it was noted that Petitioner returned from the hospital and stated that he was told that he had a dislocated jaw but that it was not back in place. It was noted that Petitioner stated that he had a CT of the head, neck and face as well as x-rays. It was noted that Petitioner was complaining of pain in the left jaw and mouth. It was noted that Petitioner had been given work restrictions at the hospital and that he was sent home for the rest of his shift. (PX1).

The records of Olin GBC Health Center reflect that Petitioner was seen on April 30, 2015 at 8:02 a.m., at which time it was noted that he stated that he was having pain in the left jaw area and right neck and that his teeth were aligned. At the time of the May 5, 2015 visit, it was noted that Petitioner complained of pain in the jaw that increased with movement and that his front bottom teeth were loose. It was noted that Petitioner stated that his jaw did not line up, that he could not close his teeth right and that he was not sure what to do. The assessment was noted to be that of possible malocclusion and loose dentition. At the time of the May 19, 2015 visit at 7:18 a.m., it was noted that Petitioner was complaining of pain in his jaw and that he stated he was sent to a doctor in St. Louis and was told that he had a broken jaw. It was noted that Petitioner was given no follow-up or a plan of care by the Dr. Sclaroff, and he called and was able to get an appointment later that day. At the time of the 12:16 p.m. visit on May 19, 2015, it was noted that

Petitioner indicated that he was told he could go back to work without restrictions and was supposed to return in a couple of weeks. It was noted that Petitioner was given a prescription for Norco but that he could not take it at work and that he had to see someone else about his neck. Petitioner was instructed to call the adjustor about the next appointment and seeking treatment for his neck. (PX1).

The medical records of Alton Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on April 29, 2015, at which time it was noted that he presented to the emergency room ambulatory via EMS after an accident at work. It was noted that while on top of a machine, Petitioner was hit in the head with a crane and had his head pinched in between the crane and the machine. It was noted that Petitioner felt his jaw snap and complained of severe left jaw pain and that he also complained of a mild headache but denied loss of consciousness, blurry vision, tinnitus, bleeding from the mouth or ears, shortness of breath, neck pain, extremity pain or pain outside of the left jaw. Petitioner underwent a CT of the facial bones, which were interpreted as revealing (1) no mandibular or other facial bone injury seen; (2) very mild right and minimal left maxillary sinus inflammatory changes. A CT of the head was interpreted as normal. A CT of the cervical spine was interpreted as revealing (1) straightening of cervical lordosis; (2) mild to moderate C6-7 and minimal C5-6 degenerative disc disease; (3) no other significant cervical spine abnormality. The diagnosis was noted to be that of injury of the mandible. Petitioner was discharged to home and given a prescription for Norco. (PX2).

The records of Alton Memorial Hospital reflect that Petitioner was seen on January 31, 2016 at which time he underwent x-rays of the cervical spine, which were interpreted as revealing (1) no acute fracture; (2) degenerative disc disease at C5-6 and C6-7. (PX2).

The medical records of Dr. Allen Sclaroff were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on May 12, 2015, June 19, 2015, September 8, 2015 and September 22, 2015 for issues related to his jaw and teeth. (PX3).

The medical records of Dr. Sandra Tate/Mercy Clinic Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on June 18, 2015, at which time it was noted that he complained of neck pain with an onset of two months ago and that it was stable since that time. It was noted that the pain started when a crane caught his head between the rail and machine and pulled the neck out and broke the jaw. The assessment was noted to be that of an acute cervical strain. Petitioner was ordered to undergo x-rays of the cervical spine, which were performed on the same date and were interpreted as revealing decreased cervical lordosis but no evidence of fracture or other osseous abnormality. Petitioner was prescribed medications and was placed on work restrictions of no lifting more than 30 pounds and no lifting above shoulder height. Petitioner was also ordered to undergo physical therapy. (PX4).

The records of Dr. Tate reflect that Petitioner was seen on September 10, 2015, at which time it was noted that he had undergone five visits of physical therapy and that he stated that it helped as long as he was doing the exercises. It was noted that Petitioner was supposed to be there on July 9, 2015 but had a flat tire on the way and did not reschedule. It was noted that there was no improvement in the pain, that the pain was described in the back of the neck that was aching, burning and a tight band in character, and that exacerbating factors were bending sideways. It was noted that Petitioner admitted to numbness or tingling in the neck and that he recently had a tooth pulled and had a post for an implant. The assessment was noted to be that of a cervical strain. Petitioner was ordered to undergo x-rays of the cervical spine, which were interpreted as revealing no fracture and good preservation of nerve root exit zones. Petitioner was also instructed to undergo physical therapy and given prescriptions. Petitioner was allowed to return to work full duty. At the time of the September 28, 2015 visit, it was noted that Petitioner had undergone five additional sessions of physical therapy with some improvement (60%). It was noted that the pain was described as in the left side of the neck, aching in character, and that exacerbating factors were bending

sideways. It was noted that Petitioner denied numbness or tingling. The assessment was noted to be that of cervical myofascial pain syndrome and cervical strain. Petitioner was ordered to undergo physical therapy and trigger point injections, which were performed on that date. (PX4).

The records of Dr. Tate reflect that Petitioner was seen on October 19, 2015, at which time it was noted that he had undergone trigger point injections and that after the physical therapy he felt great. It was noted that there was improvement of the pain and that it was described as pain in the left side of the neck, aching in character. The assessment was noted to be that of cervical myofascial pain syndrome and cervical strain. Petitioner was given another injection and was instructed to do more physical therapy. At the time of the November 9, 2015 visit, it was noted that Petitioner had undergone trigger point injections and that after physical therapy he was great for two hours and had better range of motion but felt stiff later. It was noted that there was 80% improvement of the pain and that the pain was in the left levator and posterior neck. The assessment was noted to be that of cervical myofascial pain syndrome, cervical strain and cervical degenerative disc disease. Petitioner was ordered to undergo physical therapy and trigger point injections. (PX4).

The records of Dr. Tate reflect that Petitioner called on December 3, 2015, indicating that his therapy ended last week and inquiring whether he needed any more. The records reflect that four more physical therapy sessions were ordered. At the time of the December 17, 2015 visit, it was noted that Petitioner had undergone prior trigger point injections and physical therapy, that there was 80% improvement of the pain but that he had plateaued subjectively but objectively had continued to improve. It was noted that the pain was described as pain in the neck when he turned at end ranges and was burning in character. The assessment was noted to be that of cervical strain, cervical myofascial pain syndrome and cervical degenerative disc disease. Petitioner was instructed to continue his home exercise program and was placed at maximum medical improvement. (PX4).

The medical records of ProRehab were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent physical therapy for the timeframe of June 22, 2015 through July 2, 2015. At the time of the July 1, 2015 visit, it was noted that Petitioner had been seen for five visits and had made steady improvements with his pain and mobility and that his cervical spine range of motion had improved significantly with activities of daily living. The records reflect that Petitioner also underwent additional physical therapy for the timeframe of September 21, 2015 through December 17, 2015. At the time of the September 21, 2015 visit, it was noted that Petitioner stated at re-evaluation that he was progressing well but since stopping physical therapy his neck had stiffened up again as he did not realize that he was meant to continue with his home exercise program independently after completion of therapy. At the time of the October 12, 2015 visit, it was noted that Petitioner reported that his neck had been feeling better overall but that he reported that he continued to experience a burning pain in the left upper thoracic spine with cervical active range of motion, especially left rotation. The Progress Report dated November 6, 2015 noted that Petitioner reported improvements from his initial evaluation in September 2015 and reported that he was at least 70% improved relative to his pre-treatment status. It was noted that Petitioner had pain only at very end range of rotation with his neck and that the left was more affected than the right. It was noted that the burning in the left levator scapula region was resolved and that otherwise he reported no symptoms. (PX5).

The medical records of James Nanney, PA-C/SIHF were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on January 12, 2016, at which time it was noted that he had had his head crushed in a crane 157 days ago and had a broken jaw and pulled muscles in his neck and questionable pain in his cervical column. Petitioner underwent cervical spine x-rays on that date at Alton Memorial Hospital, which were interpreted as revealing (1) no acute fracture; (2) degenerative disc disease at C5-6 and C6-7. The assessment was noted to be that of cervicobrachialgia. It was noted that Petitioner needed a massage therapist. (PX6).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was seen on April 18, 2016, at which time it was noted that he had a chief complaint of neck pain to both sides into both shoulders and upper back with headaches and restriction of motion. It was noted that Petitioner also felt that he had increasing "restless legs" since his accident. It was noted that Petitioner was referred to Dr. Tate, that trigger point injections were performed and that Petitioner had had over 30 visits of physical therapy. It was noted that Petitioner stated that the physical therapy helped at the time, but within an hour or two after leaving therapy he had increasing pain and stiffness. It was noted that Petitioner did not recall any previous problems of significance with his neck and that his symptoms were constant, worse by turning right and left and better with a neutral position. It was noted that Petitioner had mostly axial neck pain and denied significant radicular pain such as numbness or weakness. It was noted that Dr. Gornet believed that the injury could easily injure Petitioner's spine or aggravate an underlying condition that was asymptomatic. Petitioner was recommended to undergo an MRI and a CT. The Addendum noted that the MRI revealed a central disc protrusion at the C3-4 level and abutted up and deformed the cord to some extent; that foraminal views revealed significant foraminal herniation on the left at C4-5 and a larger fragment at C5-6 and disc osteophyte and fragment at C6-7; that on the right side there was a fragment at C4-5, not quite as large as the left, but that there was a very large annular tear/disc protrusion at C5-6 and a smaller disc herniation at C6-7. It was noted that the working diagnosis was disc injury at C4-5, C5-6 and C6-7. Petitioner was referred to Dr. Blake for injections at C5-6 and C6-7 and should also cover the C4-5 area. Petitioner was returned to work full duty. (PX7).

The records of Dr. Gornet reflect that Petitioner was seen on August 3, 2016, at which time it was noted that he had had injections from Dr. Boutwell [*sic*] at C6-7 and also at C5-6 that gave substantial temporary relief. It was noted that Petitioner's symptoms had returned and that he continued to have neck pain, headaches and pain in both trapezius, as well as restless legs and increasing tingling in his legs. Petitioner was recommended to undergo a CT myelogram of his cervical spine. It was noted that Dr. Gornet had placed Petitioner's low back issues "on hold" but had obtained x-rays on that date, which were interpreted as revealing normal coronal sagittal alignment, minimal degeneration and some mild facet changes at 4-5. Petitioner was recommended to undergo an MRI of the lumbar spine. It was noted that approval would be sought for disc replacement at C4-5, C5-6 and C6-7. Petitioner was returned to work full duty. At the time of the January 23, 2017 visit, it was noted that Petitioner continued to work full duty and continued to believe his symptoms affected his quality of life and most aspects of his life. It was noted that Petitioner had been seen for an IME but that Dr. Gornet did not have the results. It was noted that Petitioner's exam was unchanged and continued to show decreased biceps and wrist dorsiflexion on the right at 4/5, but that most of his symptoms were neck pain and headaches. Petitioner was returned to work full duty. The records further reflect that Petitioner returned on June 12, 2017, at which time the IME with Dr. Bernardi was apparently discussed. No reference was made to any physical examination findings at that time. (PX7).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent an MRI of the cervical spine on April 18, 2016, which was interpreted as revealing (1) annular disc bulge with superimposed left lateral recess-foraminal protrusion at C6-7 resulting in moderate to severe left greater than right foraminal stenosis, ventral cord flattening and borderline central canal stenosis; (2) bilateral foraminal protrusions at C5-6 with a highly visible edematous right lateral recess-foraminal annular tear; there are moderate to severe bilateral foraminal stenoses and borderline central canal stenosis at this level; (3) C4-5 central-left foraminal protrusion resulting in moderate left foraminal stenosis, ventral dural displacement, but no central canal stenosis; (4) left paracentral 1.2 mm C7-T1 protrusion resulting in dural displacement but no central canal or foraminal stenosis. Petitioner also underwent an MRI of the lumbar spine on October 10, 2016, which was interpreted as revealing (1) left foraminal annular tears at both the L3-4 and L4-5 levels resulting in left foraminal stenosis at both levels; no central canal stenosis is observed at either level; (2) central

annular tear and broad-based protrusion at L5-S1 resulting in dural displacement but no central canal or foraminal stenosis. (PX8).

The medical records of CT Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner underwent a CT of the cervical spine on April 18, 2016, which was interpreted as revealing (1) central C4-5 and C6-7 broad-based protrusions with endplate spurring; there is mild central canal stenosis at the C6-7 level; bilateral foraminal stenoses are present at both levels; (2) lobulated right paracentral and left foraminal protrusions at C5-6 resulting in moderate left foraminal stenosis, ventral cord flattening and mild central canal stenosis. (PX9).

The medical records of Dr. Helen Blake/Pain Rehabilitation Specialists were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner underwent a C6-C7 epidural injection on June 14, 2016 for a pre- and post-operative diagnosis of cervical radiculopathy. The records further reflect that Petitioner underwent C5-C6 ILESI with fluoroscopy on June 28, 2016 for a pre- and post-operative diagnosis of cervical radiculopathy. (PX10).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 11.

The transcript of the deposition of Dr. Matthew Gornet was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. Dr. Gornet testified that he is a board-certified orthopedic surgeon whose practice is devoted to spine surgery. (PX12).

Dr. Gornet testified that he first saw Petitioner on April 18, 2016, at which time he complained of neck pain in his shoulders, upper back, headaches, and restricted range of motion. When asked if there was any radiculopathy associated with the neck pain, Dr. Gornet testified that on physical examination Petitioner had a mild change on the right side in his biceps dorsiflexion and volar flexion that could indicate a mild nerve irritation, but that his subjective complaints were mostly of axial neck pain, headaches, restriction of motion and pain into his upper back which was typical of someone who had a neck injury. He testified that on physical examination, Petitioner had a decreased biceps wrist dorsiflexion and volar flexion on the right of 4/5, which meant a subtle irritation of the C6-C7 nerve roots. He testified that his working diagnosis at that time was that of potential disc injury or aggravation of Petitioner's preexisting degenerative condition that was asymptomatic. He testified that he ordered an MRI and a CT. (PX12).

Dr. Gornet testified that on his review of the studies Petitioner had structural pathology particularly at C4-5, C5-6 and C6-7, which he felt was consistent with his subjective complaints of neck pain and his mild subtle issues on motor strength. He testified that there was a large fragment of disc at C4-5 and C5-6 and a bone spur and a fragment of disc at C6-7, all of which would correlate with his subjective complaints. He testified that he believed that the neck pain into the upper back and shoulder area was secondary to the structural pathology that he diagnosed. He testified that he prescribed steroid injections at C5-6 and C6-7 and even up to C4-5, which Petitioner underwent by Dr. Blake on June 14, 2016 and June 28, 2016. (PX12).

Dr. Gornet testified that he next saw Petitioner on August 3, 2016, at which time he stated that the injections gave him substantial temporary relief but that his symptoms had returned. He testified that Petitioner never really described back pain but rather restless legs and tingling. He testified that he told Petitioner that if it was related to his back, they were focusing on the neck issues so he would place that on hold. He testified that he did not feel "appropriate working up two complaints at one time." He testified that at the time of this visit, he recommended a CT myelogram and indicated that he recommended disc replacement surgery at C4-5, C5-6 and C6-7. (PX12).

Dr. Gornet testified that he believed that Petitioner's current symptoms that he described of axial neck pain, headaches and upper back pain was causally connected to his work-related injury of April of

2015. He testified that he believed that authorization had not been provided for either the CT myelogram or the cervical spine surgery. He testified that he continued to see Petitioner while they awaited approval for the treatment. He testified that when he saw Petitioner on January 23, 2017, he indicated that the company was having him seen for an independent medical examination and that he was subsequently provided with a copy of Dr. Bernardi's report of April 4, 2017. (PX12).

Dr. Gornet testified that he agreed that multilevel cervical degenerative disc disease or spondylosis was an anatomic finding but that he did not believe that Petitioner's diagnosis was degenerative disc disease and spondylosis. He testified that if Petitioner had an irritated nerve root, he would tend to have referred pain down the distribution of the nerve root. He testified that he agreed with Dr. Bernardi that Petitioner did not have significant cervical radiculopathy and that he further agreed with Dr. Bernardi that Petitioner had preexisting disc degeneration. He testified that the major difference was whether to treat patients with a structural injury. (PX12).

Dr. Gornet testified that he completely disagreed with Dr. Bernardi's statement that neck pain without neurologic fixtures led to very unpredictable disc replacement surgical results. He testified that the older contention was that injured workers did not benefit from surgery in the cervical spine as well as people who were not involved in litigation. He testified that he published a paper that showed that if you treated injured workers appropriately and timely, their results were just as good as patients who were not involved with work-related injuries. He testified that his results showed that patients who had structural neck pain without significant nerve irritation benefited from surgery just as much as patients who had nerve complaints. When asked about Dr. Bernardi's questioning of his recommendation for the three-level procedure because it would be an off-label use of disc replacement devices according to the FDA, Dr. Gornet responded that the FDA did not govern the practice of medicine. He testified that he could categorically state that Dr. Bernardi had used products off-label himself and that he was present in the operating room when he did so. He testified that not only has he personally performed three-level disc replacement surgery, but that the results had been excellent. (PX12).

Dr. Gornet testified that he last saw Petitioner on June 12, 2017. He testified that upon every visit that he had seen him, Petitioner had expressed to him how this had dramatically affected his quality of life and that he was quite confident that he could help him. He testified that he was still recommending that Petitioner undergo a CT myelogram of the cervical spine and disc replacement surgery at C4-5, C5-6 and C6-7 but that he only did the CT myelogram after surgery was approved because it was invasive. He testified that he had allowed Petitioner to continue working while he awaits approval for treatment and that he did not believe it was causing any harm. (PX12).

On cross examination when asked if he had submitted three-level disc replacement in the cervical spine to a group insurance carrier and had them approve it, Dr. Gornet responded that he probably had not because of their stricter guidelines. He testified that he was not aware of group insurance that would cover three levels currently. He testified that there had been instances where group had paid for two levels and the patient had paid out-of-pocket for the third level. He testified that he has done hundreds of three-level cervical disc replacement surgeries. He testified that the only clinical information for three-level cervical disc replacements was doctors like himself who had published their results. He testified that he did not believe that there would ever be a three-level trial because the company was not going to spend $100,000,000.00 for that result. (PX12).

On cross examination, Dr. Gornet agreed that he was proposing a surgery to address disc pathology pretty much in the absence of radicular problems. He testified that he thought that Petitioner had a little bit of neurologic compromise at 5-6 and 4-5. He testified that just because there was disc pathology on MRI did not mean that Petitioner had significant neurologic findings. (PX12).

The transcript of the deposition of Dr. Robert Bernardi was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Bernardi testified that he is a board-certified neurosurgeon who limits his practice to spine surgery. (RX1).

Dr. Bernardi testified that he was familiar with cervical disc replacements and their protocols. He testified that he performed an examination of Petitioner on April 4, 2017 and that he was asked to opine on the surgical proposal made by Dr. Gornet, specifically a three-disc replacement from C4 to C7. He testified that on examination, Petitioner had neck pain that was concentrated more to the left than the right and that it was most pronounced at the base of his neck and extended all the way up to the base of his skull. He testified that Petitioner reported that the pain at the base of his skull was worse when he would extend his neck or look overhead, that Petitioner told him that when he would turn his neck it was more restricted when he would turn to the left than to the right and that this was also associated with tingling in his hands and feet. He testified that Petitioner was not having any pain beneath his shoulder blades, that he was not having any radiating arm pain and that he stated that in general the symptoms were worse with activity. He testified that Petitioner's pain complaints were not radicular. (RX1).

Dr. Bernardi testified that there were not really any objective findings on either Petitioner's general physical exam or neurologic exam. He testified that when he asked Petitioner to rotate his neck to the left and the right, he was restricted both ways but more restricted going to the left. He testified that this was a subjective finding ultimately, but that was the sole finding on the general exam. He testified that Petitioner's neurologic exam was entirely normal. He testified that his diagnosis was multi-level cervical degenerative disc disease and neck pain of uncertain etiology. (RX1).

Dr. Bernardi testified that he did not believe that the three-level cervical disc replacement surgery was indicated to cure and relieve the effects of Petitioner's work accident. He testified that cervical disc replacements and cervical fusions pretty much had equivalent outcomes in terms of the results of surgery. He testified that the indication was for individuals experiencing cervical myelopathy or cervical radiculopathy, and that Petitioner had neither of those things and had a neck ache. He testified that a neck ache was a neck ache and that about 50 different things could make the neck hurt in exactly the same way. He testified that the results from a surgery directed at treating a neck ache or neck pain without neurological findings was probably less than 50/50 and that it was generally not recommended to be done. (RX1).

Dr. Bernardi testified that Petitioner offered some lumbar complaints as well and that he reviewed a lumbar MRI. He testified that he thought that Petitioner had some fairly minor degenerative disc disease at the lowest three segments of his back and had age-appropriate degenerative changes. He testified that he did not feel that there was any causal relationship between the accident that Petitioner described and the lumbar complaints. As to the neck, Dr. Bernardi testified that he thought Petitioner should use an anti-inflammatory agent and should continue with a home exercise program. He testified that he did not think that Petitioner needed additional injections and that he did not think he needed a three-level disc replacement. (RX1).

On cross examination, Dr. Bernardi agreed that the testing and treatment that Petitioner had to the point of his examination was reasonable and necessary to diagnose, cure and relieve the effects of his work injury except that he would not have recommended the epidural injections. He testified that he thought those could be effective for people having radicular pain, which Petitioner did not have. He testified that the fact that Petitioner underwent epidural steroid injections at the direction of his treating surgeon did not make it unreasonable or unnecessary in this situation as a matter of differences in surgeons' practices and beliefs. (RX1).

On cross examination, Dr. Bernardi agreed that there were a number of different reasons for surgery in general. When asked whether improving an individual's quality of life was a reasonable cause for a surgical recommendation, Dr. Bernardi responded that approximately 90% of the surgery that a spine

surgeon did was to improve someone's quality of life. He testified that the persistence of pain and the persistence of complaints was not in and of itself an indication to have an operation and so if he did not feel that the chance of it helping them were reasonable, he would not offer them an operation. (RX1).

On cross examination, Dr. Bernardi agreed that the mechanism of injury in this case could cause injury to the cervical spine at the C4-5, C5-6 or C6-7 levels. He testified that it would be weird to injure all of them simultaneously, but it could to one of those discs. He testified that he does not perform disc replacement surgery. He testified that it was not widely performed and that cervical fusions were still done far more frequently than cervical disc replacements. He testified that there was some debate about the effectiveness as compared to a fusion, but that most of the studies were showing that the safety profile and the results were essentially the same between the two operations. He testified that the FDA did not govern the practice of medicine but that it did determine which products were safe. He agreed that ultimately it was up to the treating physician whether to use a medication or product if that physician determined that it would be beneficial to the patient. He agreed that it was not unusual, including in his own practice, to use products or medications off-label if it was beneficial to the patient. (RX1).

On cross examination, Dr. Bernardi agreed that Petitioner had experienced axial neck pain from the date of accident through the date of his examination and that it was evidenced throughout the medical records from the emergency room up through his examination. He agreed that the injections provided Petitioner with temporary relief of his symptoms, that it then wore off and that it was not unusual. He testified that injections were a short-term pain relief issue and that it was probably not accurate to say that the epidural injections fixed the problem but that the injections just made the person feel better while Mother Nature fixed it. (RX1).

On cross examination, Dr. Bernardi agreed that Petitioner's neck pain could now be classified as chronic given that 2+ years that had lapsed since his accident. He agreed that Petitioner's cervical spine symptoms appeared to be causally related to his April 29, 2015 work accident. He testified that he found Petitioner to be cooperative with his examination and that he found him to be exceptionally agreeable. He denied having found any symptom magnification or malingering. He agreed that there were no Waddell's signs on examination. (RX1).

On cross examination, Dr. Bernardi agreed that he diagnosed multi-level cervical degenerative disc disease. He testified that he did not agree that Petitioner's symptoms that he voiced to him and the other physicians since his accident were emanating from C4-5, C5-6 and C6-7 and testified that he did not know where they were emanating from. He testified that it was theoretically possible that they were emanating from those levels, although Petitioner's symptoms were not acting like an aggravation of degenerative disease in that they had been more prolonged than was typical. He testified that if physicians were honest with themselves, with these types of symptoms not associated with neurologic features, finding the precise source of the pain was essentially impossible. (RX1).

On cross examination, Dr. Bernardi agreed that the multi-level cervical disc disease that he diagnosed in Petitioner could be completely asymptomatic. He testified that by all accounts it may still be asymptomatic and that that was the issue. He testified that they did not know what was causing Petitioner's symptoms. He testified that it would be extremely unusual to have three simultaneously symptomatic discs in the cervical spine and that aggravation of the degenerative discs was the same process. He testified that he was concerned that Petitioner had neck pain of uncertain etiology and was looking at a fairly extensive operation using a device in an off-label fashion at multiple levels. He testified that he would not offer Petitioner the surgery for this and that this was ultimately his judgment as a physician and a surgeon. He testified that he would not offer it to Petitioner because he did not think it was in his best interests. He testified that he did not agree that if Petitioner underwent the recommended surgery that at some point post-surgically a CT myelogram would be indicated. (RX1).

On redirect, Dr. Bernardi testified that he did not equate the administration of an epidural in the same vein as a three-level disc replacement in terms of the scrutiny that needed to be applied to the two procedures. He testified that the three-level disc replacement needed to be scrutinized greater. When asked if he would characterize the scrutiny used in the use of Neurontin in an off-label fashion to treat radicular pain versus seizures as the same as a three-level disc replacement versus a one-level disc replacement, Dr. Bernardi responded that the degree of invasiveness and the risks associated with it were much greater in any surgical procedure. He testified that Petitioner was defining chronic pain, but every indication was that it was not incapacitating or disabling him. (RX1).

CONCLUSIONS OF LAW

With respect to disputed issues (F) pertaining to causation and (K) pertaining to prospective medical treatment, given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being in the cervical spine is causally related to the accident of April 29, 2015. While the Arbitrator finds that Petitioner's current condition of ill-being in the cervical spine is causally related to the accident, however, the Arbitrator does not find the prospective medical treatment as recommended by Dr. Gornet to be either reasonable or necessary. As such, Petitioner's request for the prospective medical treatment as recommended by Dr. Gornet for the cervical spine is hereby denied.

Furthermore, the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being in the lumbar spine is causally related to the accident of April 29, 2015. As a result thereof, Petitioner's request for any prospective medical treatment to the lumbar spine is hereby denied.

As it pertains to the lumbar spine condition, the Arbitrator places significant weight upon the opinions of Dr. Bernardi who testified that he did not feel that there was any causal relationship between the accident that Petitioner described and the lumbar complaints. (RX1). Although Petitioner testified that after the accident it appeared that his restless leg syndrome grew worse and that he has had that condition for as long as he could remember, Petitioner further admitted that he did not know if the reason the condition was worse was because of the accident. The Arbitrator is not persuaded by Dr. Gornet's assertion in the medical records that he did not feel "appropriate working up two complaints at one time." (PX7). Based on the foregoing, the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being in the lumbar spine is causally related to the accident of April 29, 2015. As a result thereof, Petitioner's request for any prospective medical treatment to the lumbar spine is hereby denied.

As it pertains to the cervical spine condition, under section 8(a) of the Act an employee is only entitled to recover reasonable medical expenses which are causally related to the accident. The award should only reflect those services which were determined to be required to diagnose, relieve, or cure the effects of claimant's injury. What is reasonable and necessary is a question of fact to be determined on a case-by-case basis. (*Univ. of Illinois v. Indus. Comm'n.*, 232 Ill. App. 3d 154, 596 N.E. 2d 823 (1st Dist.1992). Reasonableness of medical services is defined as those services that are usual and customary for similar services in the community in which they are rendered. (*Gen. Tire & Rubber v. Indus. Comm'n.*, 221 Ill. App. 3d 641, 582 N.E. 2d 744 (5th Dist. 1991).

Having reviewed and considered the entire of the medical evidence in the matter, the Arbitrator finds that Petitioner has failed to establish the prospective medical treatment recommended by Dr. Gornet is reasonable or necessary to cure or relieve the symptoms of his cervical spine condition. The Arbitrator finds Dr. Bernardi's opinions to be more persuasive than those offered by Dr. Gornet and, as such, denies

Petitioner's request to award the prospective medical treatment as recommended by Dr. Gornet including, but not limited to, the three-level cervical disc replacement surgery and the pre-operative CT myelogram.

The Arbitrator finds to be more persuasive Dr. Bernardi's position that the identifiable location of Petitioner's symptoms cannot be determined and that simply replacing all three cervical discs will not provide a high probability of alleviating the symptoms. The Arbitrator finds Dr. Gornet's testimony that he is confident that Petitioner's symptoms will be addressed adequately if the surgery is performed does not outweigh the significant risks associated with a three-level disc replacement surgery. The Arbitrator notes that Petitioner has missed no time from work and that he has not been placed under any restrictions, although he certainly testified that his range of motion is decreased and that he does experience a low level of chronic pain on a daily basis. Additionally, the Arbitrator notes that Dr. Gornet's testimony does not seem to support Petitioner's cervical spine condition deteriorating if the surgery were not to be performed.

Furthermore, the Arbitrator further finds to be significant in this case Dr. Bernardi's testimony that they did not know what was causing Petitioner's symptoms, that it would be extremely unusual to have three simultaneously symptomatic discs in the cervical spine and that aggravation of the degenerative discs was the same process, and that he was concerned that Petitioner had neck pain of uncertain etiology and was looking at a fairly extensive operation using a device in an off-label fashion at multiple levels. (RX1). Frankly, the Arbitrator is admittedly concerned by the request for the award of a such a significant surgical procedure that has apparently not yet been approved by the U.S. Food & Drug Administration.

Based on the foregoing, the Arbitrator does not find the prospective medical treatment for the cervical spine as recommended by Dr. Gornet to be either reasonable or necessary. As such, Petitioner's request for the prospective medical treatment as recommended by Dr. Gornet for the cervical spine is hereby denied.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary and causally related to his work accident of April 29, 2015. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 11, **exclusive of the October 10, 2016 lumbar MRI performed at MRI Partners of Chesterfield**, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PEDRO CAZARES,

Petitioner,

vs. NO: 16 WC 13772

CHICAGO HEIGHTS STEEL,

18IWCC0461

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Decision of the Arbitrator only to increase the compensation awarded Petitioner for the injury sustained to his right hand as a whole on April 18, 2016. Petitioner was awarded 9% loss of use the right hand. The Commission finds increasing the award to 15% loss of use of the right hand to be more appropriate compensation.

The Commission, in reviewing the "Findings of Fact" within the Decision of the Arbitrator, finds it to be an accurate summation of Petitioner's testimony concerning the residual effects of his injuries. Petitioner testified of continuing pain in his right hand that he rated as 3 or 4 out of 10 on a scale of 0 to 10 with 10 representing the most pain and to continuing to treat this pain with over-the-counter pain medication. Petitioner also testified to the injuries impairing his ability to perform both work activities as well as domestic activities. Petitioner's testimony when weighed against his medical records gives the Commission no reason to question his credibility.

Section 8.1(b) of the Act requires consideration be given to specified factors when determining permanent partial disability for compensable injuries occurring on or after September 1, 2011. The Arbitrator presiding over Petitioner's claim, in accordance with the Act, weighed the factors that are to be considered under Section 8.1(b). With the exception with one factor, the Commission agrees with the weight the Arbitrator placed on the factors. The factor

the Commission disagrees with the Arbitrator is with respect to the weight the Arbitrator placed on Petitioner's age at the time his accident.

Age at the time of the injury is the third factor that is to be considered, pursuant to Section 8.1(b), when determining permanent disability for compensable injuries. Petitioner was 29 years old on April 18, 2016, the day he sustained his compensable injuries. The Arbitrator put some weight to that fact. The Commission believes significant weight should be given to it as Petitioner will have to work and live with the residual effects for decades to come. It is for this reason the Commission increases the award with respect to Petitioner's right hand.

The other injury Petitioner sustained on April 18, 2016, the injury to Petitioner's right index finger, meets the statutory threshold under Section 8(e) of the Act to be considered a loss of the entire finger. The Commission, therefore, abstains from modifying the award with respect to Petitioner's right index finger.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $563.01 per week for a period of 43 weeks, as provided in §8(e) of the Act for the reason that the injuries sustained caused the 100% loss of use of the right index finger.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $563.01 per week for a period of 30.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 15% loss of use of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $575.00 to MidAmerica Orthopedics, pursuant to the fee schedule, as provided in §8(a) and §8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $42,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

JUL 25 2018

DATED:
KWL/mav
O: 07/16/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CAZARES, PEDRO
Employee/Petitioner

Case# **16WC013772**

CHICAGO HEIGHTS STEEL
Employer/Respondent

18IWCC0461

On 11/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% 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:

0154 KROL BONGIORNO & GIVEN LTD
CRAIG E BUCY
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
NICOLE M SCHNOOR
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

PEDRO CAZARES
Employee/Petitioner

v.

CHICAGO HEIGHTS STEEL
Employer/Respondent

Case # 16 WC 13772

Consolidated cases: n/a

18IWCC0461

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

DISPUTED ISSUES

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

FINDINGS

18IWCC0461

On **APRIL 18, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$48,794.20**; the average weekly wage was **$938.35**.

On the date of accident, Petitioner was **29** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$5,630.13** for TTD, **$625.57** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$6,255.70**.

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law*:

1) The Respondent shall pay the Petitioner: A) permanent partial disability benefits of **$563.01**/week for **18.45** weeks, because the injuries sustained caused the Petitioner an **9%** loss of the right hand, as provided in Section 8(e)9 of the Act; ***AND***, B) permanent partial disability benefits of **$563.01**/week for **43** weeks, because the injuries sustained caused the Petitioner a **100%** loss of the right index finger, as provided in Section 8(e)8 of the Act;

2) The Respondent shall pay reasonable and necessary medical services of $575.00 to MidAmerica Orthopedics, pursuant to the Fee Schedule, as provided in Sections 8(a) and 8.2 of the Act;

3) The Respondent shall be given a credit for all PPD benefits previously paid pursuant to Section 8(e) of the Act;

4) The Respondent shall pay the Petitioner compensation that has accrued from **February 14, 2017** through **October 30, 2017**, and shall pay the remainder of the award, if any, in weekly payments;

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

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

Signature of Arbitrator

NOVEMBER 21, 2017
Date

NOV 27 2017

PEDRO CAZARES v. CHICAGO HEIGHTS STEEL

16 WC 13772

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on October 30. 2017. The issues in dispute were medical bills, the Respondent's credit, and the nature and extent of the injury. (*Arbitrator's Exhibit* 1). The parties requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act, and agreed to receipt of this Arbitration Decision via e-mail. (*Arbitrator's Exhibit* (hereinafter, *AX*) 1).

FINDINGS OF FACT

On April 18, 2016, the Petitioner[1] was a right-hand dominant 29-year-old machine operator employed by the Respondent since September of 2005. His job duties included operating a punching machine, cutting bars in the machine, extracting the punches, and performing low level maintenance on the punch press machine when needed. While operating the punch press, the Petitioner would insert a metal bar into the machine and the machine would then use metal blades to cut/punch out the required piece.

On the stipulated accident date of April 18, 2016 (*AX* 1), the punching machine suffered a malfunction. As Petitioner was adjusting bolts inside the machine to repair the issue, the punch blades descended and severed his right index finger. The Petitioner was transported by ambulance to the emergency room of Franciscan St James Hospital. (*Petitioner's Exhibit* 1). He was diagnosed with a partial amputation of the right index finger and referred to a hand surgeon. (*Petitioner's Exhibit* (hereinafter, *PX*) 1 and 2).

The Petitioner saw Dr. Gary Kronen of MidAmerica Orthopedics on April 19, 2016. (*PX* 2). Dr. Kronen diagnosed Petitioner with a partial transphalangeal amputation of the right index finger and prescribed surgery. (*PX* 2). The Petitioner underwent a revision amputation of the right index finger on April 20, 2016. (*PX* 3). Dr. Kronen amputated the finger at the head level of the metacarpal due to the extensive skin damage suffered during the accident. (*PX* 3).

[1] The Petitioner primarily speaks Spanish and testified via an interpreter.

The Petitioner followed up with Dr. Kronen on May 6, 2016, and Dr. Kronen prescribed a course of occupational therapy while also imposing a one pound lifting restriction. (*PX* 2). On June 3, 2016, the Petitioner reported to Dr. Kronen he still had grip weakness and discomfort in his right index finger. Dr. Kronen continued the Petitioner's physical therapy program and lifting restriction. (*PX* 2). The Petitioner then returned to Dr. Kronen on July 29, 2016 and reported increased pain at the amputation site and continued grip strength weakness. Dr. Kronen recommended continued occupational therapy and that the Petitioner consider further revision surgery to address his complaints. (*Id.*).

The Petitioner's symptoms did not improve and he returned to Dr. Kronen on September 23, 2016. (*PX* 2). Due to the Petitioner's continued complaints of weakness with pain, Dr. Kronen prescribed surgery to correct the issue. (*PX* 2). The Petitioner subsequently underwent a right metacarpal revision amputation of the right index finger on October 15, 2016. (*PX* 3). As part of the operation, Dr. Kronen removed the right metacarpal from Petitioner's right hand. (*PX* 2). The Petitioner then returned to his occupational therapy program and met with Dr. Kronen on November 22, 2016. (*PX* 2). Dr. Kronen recommended continued therapy and returned the Petitioner to modified duty before releasing the Petitioner to full duty work on January 17, 2017. (*Id.*) Dr. Kronen subsequently found the Petitioner at maximum medical improvement (MMI) on February 14, 2017. (*Id.*).

After the accident, the Petitioner was off work from April 19 through May 9, 2016. After the second surgery, he was off work from October 12 through November 22, 2016. He received temporary total disability and temporary partial disability benefits while he was off work. (*AX* 1). The Petitioner testified, prior to his accident on April 18, 2016, he was not having any issues with his right index finger or right hand and he is right-hand dominant. He also did not have any prior injuries to the right index finger or right hand.

The Petitioner indicated he returned to the same position he was working prior to the injury. Although Petitioner has returned to work without restrictions, he noted he struggles with many of his job duties. He testified he has trouble gripping mallets, pliers and other handheld tools required for the job. His also noted his job duties now take longer to perform. He struggles with job duties requiring use of two hands, such as holding the bar with one hand and using a tool with the other. The Petitioner continues to complain of grip weakness in his right hand. The Petitioner obtained certification to operate a crane through the Respondent and had, on occasion, operated a crane as part of his job duties prior to the accident. However, he has not operated the crane since his return to work. The Petitioner noted he reported his difficulties performing his job duties to his foreman.

The Petitioner continues to experience pain in his right hand, especially at the end of the work day, and rates his pain level at 3 or 4 out of 10. He takes Advil or Tylenol to treat his

symptoms and notices that cold weather results in stiffness in his right hand. He also testified he remains very self-conscious about how his scar appears while holding hands with his wife or shaking someone's hand. He also struggles with basic everyday chores like cooking, holding a knife, unloading groceries, playing sports, and any activity requiring the use of both hands at the same time.

Mr. Mark Giblin, general supervisor for the Respondent, testified he is familiar with the machine that injured the Petitioner. Mr. Giblin noted that Petitioner works as part of a 3-man team on the machine, with one person working the shakedown table, one person operating the machine, and one person inspecting the bars as they exit. Mr. Giblin stated job duties are rotated among the unit and he did not consider the work to be physically demanding. Mr. Giblin confirmed the Petitioner had operated a crane prior to his injury and stated the lack of an index finger would causes issues operating a crane. Mr. Giblin was unaware of any requests for modifications to job duties or complaints from the Petitioner.

CONCLUSIONS OF LAW

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

Issue J: *Medical bills*

The Petitioner presented an outstanding medical bill from MidAmerica Orthopedics for dates of service June 23 and October 25, 2016, in the amount of $575.00. (*PX* 4). The Petitioner was in occupational therapy on June 23 and saw Dr. Kronen for a follow up examination on October 25. The Arbitrator finds that June 23, 2016, and October 25, 2016, dates of service to be reasonable and necessary. The Arbitrator orders the Respondent to pay the outstanding medical bill of $575.00 directly to MidAmerica Orthopedics, pursuant to the fee schedule.

Issue L: *Nature and extent*

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

(a) A physician licensed to practice medicine in all 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 from (a) above;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

(See 820 ILCS 305/8.1b)

With regards to factor (i) of Section 8.1b of the Act:

i. The Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence by either party. As such, the Arbitrator therefore gives ***no weight*** to this factor.

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

ii. The Arbitrator finds the Petitioner continues to work as a machine operator for the Respondent, the same position he held prior to his accident. As such, the Arbitrator therefore gives ***no weight*** to this factor.

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

iii. The Arbitrator notes that the Petitioner was 29-years-old at the time of the accident. Because the Petitioner continues to complain of right hand pain and stiffness and must cope with those symptoms for several years in the future, the Arbitrator therefore gives ***some weight*** to this factor.

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

iv. The Arbitrator notes that the Petitioner has returned to full duty work in his prior position as a machine operator for the Respondent and his rate of pay has not decreased since his accident. As such, the Arbitrator therefore gives ***some weight*** to this factor.

With regards to factor (v) of Section 8.1b of the Act:

v. The Petitioner's treating medical records show he was diagnosed with a partial transphalangeal amputation of the right finger. He underwent amputation revision surgery with Dr. Kronen on April 20, 2016. (*PX* 3). The Petitioner underwent occupational therapy but had continued pain and grip weakness complaints in the right hand, leading to a second surgery performed by Dr. Kronen on October 15, 2016. (*PX* 3). As part of the second surgery, Dr. Kronen removed the right index metacarpal from Petitioner's right hand. (*PX* 3). Petitioner underwent a second round of occupational therapy and was released at maximum medical improvement on February 14, 2017. (*PX* 2). Petitioner has continued complaints of pain in his hand, especially after a day of work. He rates the pain as a 3 or 4 out of 10 and takes Advil or other over-the-counter medication to deal with his pain. He takes longer to perform his job duties at work and struggles with two handed tasks. Outside of work, he is very self-conscious with the scar's appearance due to its prominence on his right hand. He does not like to hold his wife's hand in public or shake hands anymore. He continues to have difficulties with basic everyday chores like cooking, holding a knife, unloading groceries, playing sports, and any activity requiring the use of both hands at the same time. As such, the Arbitrator therefore gives ***significant weight*** to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of an **9%** loss of use of the right hand pursuant to Section 8.1b and Section 8(e)9 of the Act. Additionally, the Petitioner suffered a complete amputation of his right index finger and, pursuant to Section 8(e)8 of the Act, sustained permanent partial disability to the extent of a **100%** loss of use of the right index finger.

Issue N: *Respondent's Credit*

The Respondent had issued statutory PPD benefits for the amputated finger. (*AX* 1). Some of the checks the Respondent had issued went uncashed and had to be reissued. Prior to the hearing, the Respondent became aware Petitioner had not received all owed benefits and issued a check for two (2) weeks of PPD benefits. (*Respondent's Exhibit* 1). On the date of the hearing, the parties discovered the Petitioner was missing one (1) extra week of PPD benefits. As of the date of the hearing, the Petitioner had only received and cashed checks covering 40 weeks of PPD benefits. The Respondent entered an exhibit into evidence showing payment of

18IWCC0461

two (2) weeks of PPD benefits made on October 27th and stated on the record they would be issuing the last owed week of PPD benefits. (*RX* 1). The Petitioner stated on the record they were not seeking penalties or fees regarding owed PPD benefits from the statutory amputation.

As of the date of the hearing, Respondent had issued **$23,646.42** in PPD benefits for which they are entitled to a credit.

Signature of Arbitrator

NOVEMBER 21, 2017
Date

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

Laura Caponigro,

Petitioner,

vs. NO: 13 WC 35011

Springfield Park District,

18IWCC0462

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 14, 2017 is hereby affirmed and adopted.

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

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

No bond is required for 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: JUL 25 2018
SJM/sj
o-7/12/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CAPONIGRO, LAURA
Employee/Petitioner

Case# **13WC035011**

18IWCC0462

SPRINGFIELD PARK DISTRICT
Employer/Respondent

On 12/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

4128 RUBENS AND KRESS
FRANK KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

0332 LIVINGSTONE MUELLER ET AL
KENNETH BIMA
PO BOX 335
SPRINGFIELD, IL 62705

18IWCC0462

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

Laura Caponigro
Employee/Petitioner

v.

Springfield Park District
Employer/Respondent

Case # 13 WC 35011

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **11/09/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/07/2013**, 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 **$7,384.00**; the average weekly wage was **$142.00**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$5,436.56** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$2,500.00** for other benefits (an advance), for a total credit of **$7,936.56**.

ORDER

Respondent shall pay temporary total disability benefits of **$142.00/week** for **38 weeks**, commencing **6/17/13** through **12/5/13** and **3/4/14** through **6/7/14**, as provided in Section 8(b) of the Act.

Respondent shall satisfy the Illinois Department of Healthcare and Family Services lien in the amount of **$534.56** as stipulated. Respondent has no obligation to pay any additional medical bills.

Respondent shall pay Petitioner permanent partial disability benefits of **$142.00/week** for a period of **50 weeks** as provided in Section 8(d)(2) of the Act, because the injury sustained caused **10% loss of use of the person as a whole.**

Respondent is to receive a credit of **$7,936.56** representing temporary total disability payments and a PPD advance.

Respondent shall pay Petitioner compensation that has accrued between **May 7, 2013** and **November 9, 2017** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

December 8, 2017
Date

DEC 14 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner started working for Respondent in the spring of 2011. She worked part-time as a maintenance worker performing cleaning duties. Wage records reflect that in May of 2013, Petitioner was working approximately 17 hours per week at a rate of $8.25/hour (RX1).

On 5/07/2013 the Nelson Center manager asked Petitioner to clean the locker rooms in preparation for the opening of the pool season. As Petitioner was cleaning the urinals, she poured bleach into them. Subsequently, Petitioner testified that a cloud of smoke developed and she felt like she could not breathe. Petitioner testified that she immediately stepped outside to get some fresh air which made her breathing worse. Petitioner then proceeded into her manager's office who advised the director of the Nelson Center to take her immediately to the emergency room.

Petitioner was seen at the St. John's Hospital emergency room. The history at the emergency room indicates that Petitioner reported a chief complaint of chemical exposure due to inhaling bleach fumes. Petitioner was administered oxygen and a nebulizer. An x-ray of the chest was secured and interpreted as being negative. Petitioner returned to the emergency room that evening with continued complaints of shortness of breath. Petitioner was prescribed Prednisone and Norco. The physician at St. John's recommended that Petitioner avoid smoking, take medicine as directed for severe pain, and follow up with her primary care physician, Dr. Drapiza, as needed. (PX1)

Petitioner was seen by Dr. Drapiza on 5/10/2013. The notes from that date indicate that even with nebulizer treatment, she had shortness of breath. Due to continued complaints of shortness of breath, Dr. Drapiza prescribed Ventolin and Advair. Dr. Drapiza also refilled Petitioner's Norco. Petitioner advised Dr. Drapiza that she did not smoke anymore (RX5).

Petitioner returned to the St. John's emergency room on 5/27/2013 with continued chest pain and shortness of breath. Dr. John Byrnes, noted that because the condition had not resolved nearly three weeks after exposure, Petitioner should either see her primary care doctor or see a pulmonologist. Petitioner's Prednisone and Norco were refilled and she was referred back to her primary care physician (PX1).

On 6/12/2013, Petitioner was seen at the Springfield Clinic Prompt Care with continued complaints of chest pain and shortness of breath. Petitioner was administered a steroid injection and advised to increase her Advair to twice a day (PX3).

At the referral of Dr. Drapiza, Petitioner was seen by Dr. David Crabtree (Central Illinois Allergy) for a pulmonary consult on 6/18/2013. Dr. Crabtree noted that this appointment was to evaluate Petitioner, who had persistent shortness of breath, chest tightness and cough after exposure to Chlorine gas. The description that she gave described a significant amount of chlorine inhalation with a cloud of whitish/gray smoke coming up to a non-ventilated room. Dr. Crabtree noted that this gas is often a major irritant, but can cause damage to the airway and theoretically could cause either parenchymal damage and/or hyperactivity of the airways after an episode like the one Petitioner had. Dr. Crabtree also noted that Petitioner smoked cigarettes but she reported stopping as of May 7, 2013 since breathing was so difficult. Dr. Crabtree ordered a cotinine level to document the condition as he noted that there was likely to be legal issues from Petitioner's work exposure. Dr. Crabtree

performed a pulmonary stress test. Dr. Crabtree noted "Her exam today was completely negative with no adventitious lung sounds appreciated, and her chest x-ray was reviewed also looking quite normal as well." Dr. Crabree diagnosed Petitioner with acute bronchitis, bronchiolitis, and subacute obliterative bronchiolitis. Dr. Crabtree prescribed Advair, Albuterol, and Prednisone and recommended that Petitioner avoid chemical exposure, dust, and second hand smoke. Dr. Crabtree recommended further diagnostic studies including a CT scan of the chest that was secured on 6/24/2013 (PX1)[1].

On 6/28/2013 Petitioner returned to Drapiza with continued pain complaints. At Petitioner's request, Dr. Drapiza refilled Petitioner's Norco (RX5).

Petitioner continued to treat with Dr. Crabtree. She was seen on 7/02/2013. On that date, Dr. Crabtree noted that Petitioner seemed a bit better, but that she still complained vehemently of dyspnea (labored breathing), adding that he did not expect complete healing for several months. Dr. Crabtree's assessments of Petitioner included inhalation of chlorine gas, shortness of breath, acute bronchitis, subacute obliterative bronchiolitis, and bronchiolitis. at which time additional pulmonary tests were secured. Dr. Crabtree noted "The findings on her HRCT are consistent with her acute lung inhalation injury that she has described. Her PFT has improved significantly both with her lung volumes (less restriction) and her DLCO is better as well, why she so vehemently complains of the chest symptoms, I cannot tell as the symptoms are not at all consistent with the clinical, exam, and radiographic findings." On that date, Dr. Crabtree elected to keep Petitioner off work for another month as she finished the Prednisone and continued her inhaler regimen (RX4).

Petitioner followed up with Dr. Crabtree on 8/20/2013. On that date, Petitioner reported that her dyspnea was worse and very symptomatic. On this date, Dr. Crabtree noted that a representative from workers' compensation was present without his authorization. Dr. Crabtree asked her to leave as he felt that Petitioner was his patient, not the carrier. From a medical standpoint, Dr. Crabtree noted that Petitioner was feeling worse. He also noted that Petitioner's lung volumes looked better, but he was surprised that she had a positive methacholine challenge. Dr. Crabtree also noted that a second opinion of Dr. Peter Tuteur of Washington University at St. Louis was pending because of doubts with respect to his diagnosis. Additional pulmonary tests secured on that date noted that Petitioner's lung volume looked better, but she demonstrated a positive Methacholine challenge. Dr. Crabtree noted that Petitioner presented with a difficult situation and stated "With her improved lung volumes and diffusion capacity, I would expect that she has healed the injury from the inhalation and if she is having symptoms it may be the asthma-like condition for which she appears to now be suffering from?? The cause and effect of this underlying process is impossible to sort out completely. But I do agree it is not likely due to RADS of a non-immunologic mechanism. I do not think this is far out that she is still at risk from being in the work place with the obvious exception of chlorine inhalation." Dr. Crabtree advised Petitioner to continue on the same asthma inhaler regimen and noted that he wanted to see the results of an independent medical evaluation which was scheduled (RX4).

At Respondent's request, Petitioner was seen by Dr. Peter Tuteur for an independent medical evaluation on 8/29/2013. Dr. Tuteur noted that Petitioner began smoking at age 13 and continued until age 37, typically at the rate of 4 cigarettes per day. Since the episode in May, Petitioner's cigarette use had been markedly decreased further, almost never exceeding more than half a cigarette a day. Dr. Tuteur indicated that Petitioner was wearing a nicotine patch. He also noted that, unfortunately, there was persistent environmental tobacco smoke emanating from her mother's smoking in the house in which they both live, as well as in the automobile during the car ride on the date of the IME. As part of his evaluation, Dr. Tuteur secured a history from Petitioner, reviewed medical records, and performed additional laboratory testing. The laboratory data included a chest x-

[1] PX 1 and RX 1 are both Dr. Crabtree's records.

ray, CT scan, pulmonary function studies and Methacholine challenge test. Petitioner described to Dr. Tuteur that she experienced exasperations in response to a wide variety of situations including high heat and humidity, exercise and chemical smells. Petitioner noted that she was unable to walk her dog or clean her home. Petitioner stated that perfumes, colognes, and hairsprays, initiated chest heaviness and breathlessness. Petitioner noted that she leaves the room when cooking is taking place and that Carpet Fresh exacerbates her symptoms as well as ambient tobacco smoke. Dr. Tuteur read the reports of pulmonary function studies to have been essentially normal. He noted that the total lung capacity had been normal without restriction. The methacholine challenge tests had been performed at least twice with the first negative, and the second positive. Dr. Tuteur personally reviewed the images associated with a CT scan. He found extensive mediastinal and hilar calcification was noted consistent with old healed granulomatous disease. In addition, he found irregular heterogenously distributed bronchial wall thickening of the smaller visible airways. He found no nodular densities or emphysema. Dr. Tuteur administered another methacholine challenge test. It demonstrated a PC20 of .25 mg/ml., reflecting a markedly positive test, further noting that reversal took place with albuterol. Dr. Tuteur diagnosed Petitioner with chemical (irritant) induced bronchial hyperactivity. He specifically noted that this condition was not an allergic phenomenon, but one due to the exposure to irritant low molecular weight chemicals such as the compounds generated when bleach is added to hydrochloric acid solution. Dr. Tuteur noted that treatment should consist of not only ongoing scheduled medication but avoidance of exposure to triggers by maintaining exquisite environmental control to eliminate triggers. Dr. Tuteur stated that Petitioner should not return to work at the Nelson Center or any other environment associated with the triggers. Dr. Tuteur opined that ideally a home-based work situation should be sought. Lastly, Dr. Tuteur counseled Petitioner that she should be free of tobacco smoke (PX5).

Petitioner followed up with Dr. Crabtree on 10/01/2013. Petitioner noted that she was doing the same with shortness of breath and coughing complaints. Petitioner advised Dr. Crabtree that Dr. Tuteur felt that she should not be at work in the short or long-term in the environment that she was in. Dr. Crabtree kept Petitioner on the same medication regimen and recommended that she avoid exposure to triggers that may aggravate her condition. (RX 4)

Petitioner was next seen by Dr. Crabtree on 12/02/2013. The history in Dr. Crabtree's record states "Since we last saw this lady, she is still coughing and SOB by report but she sure looks pretty good. She has a PFT that now shows all normal with a very mild reduction in her diffusion capacity." Dr. Crabtree changed Petitioner from Advair to Dulera200. Regarding her work status, Dr. Crabtree noted "I do not nor did I ever say that this patient cannot work, I simply said that I am saying that she should not be exposed to chemicals that she used in the job she was in. She can do any other work that does not include exposure to chemicals. I have nothing else to add for her underlying illness as she is baseline and not likely to worsen from here. The reactivity (Methacholine positivity) is resolved with increased Advair strength so I doubt there is anything else reversible at this time." (PX4)

Petitioner returned to work for Respondent on December 6, 2013. She continued to work for Respondent through March 3, 2014. Petitioner testified that she sat at a desk at the Nelson Center answering phones.

Petitioner returned to see Dr. Crabtree on 3/04/2014. Dr. Crabtree wrote that since she had returned to work, Petitioner noted much more frequent episodes of coughing, congestion, and wheezing. He indicated that she was getting slowly better, but now, by her history and her report, she was not getting along nearly as well as she had before returning to work. He wrote that she related one episode of chemicals being used by a plumber that threw her into an "attack." Dr. Crabtree also noted that Petitioner related frequent awakenings at night with coughing and shortness of breath that have also been recent in occurrence. He noted that this in and of itself would not make him think of work exposures, but this supposedly was not apparent to her report prior to going

back to work. He also wrote that her pulmonary function tests (PFT) on that date was again showing much more reactivity than they had in the past. Dr. Crabtree noted "Her PFT while normal, other than the Methacholine that dropped her by 21% with a single breath and this is much more significant of a drop than she has had on any prior PFT/Methacholine. She still tells me that she does not smoke and is never around the smoke anymore because it causes her to cough, but we did check serum nicotine and cotinine levels with both being well above the limit for even smokers, let alone second hand exposure. So I have to believe that she is still smoking and this is not going to allow her lungs to heal and is also much more likely a trigger to ongoing symptoms than anything in the work place with her new area away from the chemicals." Based on the recent exacerbations, Dr. Crabtree placed Petitioner off work. Dr. Crabtree noted that "It will not be possible to keep her lungs improved if she does not comply with smoking cessation totally and completely now and forever." Dr. Crabtree increased Petitioner's inhaled steroid (PX4).

Petitioner returned to Dr. Crabtree on 4/08/2014. Petitioner reported that her symptoms improved which she felt was due to the fact that she was away from her prior work environment. Dr. Crabtree noted "I wish I could have more tools than I presently have as I am unsure if this young woman truly has acute disease or [if] she actually does not want to work. I have evaluated her as best I can and for all of the work-related issues that she has had and while it remains in question, the data would suggest that she is not feigning these episodes. I had obtained nicotine and cotinine levels, both of which were quite high but it was told to me for the first time that Laura has been on a nicotine patch for over a year since the time that she claimed smoking cessation. Will continue to monitor after work related exposure issues can be explored. We will have to make a decision about her ability to work. Again, I know this young woman is able to work but are these exposures in the workplace at the Nelson Center too much for her to tolerate??" She remained off work. (PX4).

Petitioner saw Dr. Crabtree for the last time on 5/08/2014. Dr. Crabtree noted that Petitioner continued to describe increasing incidents of asthma. Dr. Crabtree noted that he asked Petitioner to do a peek flow meter which did not show any significant variability even when Petitioner related terrible symptoms. Dr. Crabtree further noted "I wish there was more to do, but it does appear that this lady is left with persistent bronchiospasm post inhalation injury in the work place having inhaled a high concentration of chlorine gas while cleaning toilets at her place of employment. Since that time she relates very significant episodes of shortness of breath and wheezing that are triggered by increasingly lower level triggers. Her description of her symptoms are out of proportion to the objective findings we have had for her all along. It appears that going back to work with the Park District will not be possible, but I by no means feel that this lady is permanently or totally disabled. She describes her triggers as many and very small amounts of these substances are required to cause her to "exacerbate." Dr. Crabtree recommended that Petitioner avoid triggers in a trial by error manner. Dr. Crabtree recommended that Petitioner avoid extreme weather conditions >10° Fahrenheit and <90°Fahrenheit. Dr. Crabtree also recommended that Petitioner avoid extreme dust and dirty environments. Lastly, Dr. Crabtree noted that it was imperative that Petitioner avoid being around smoke (PX4).

Consistent with Dr. Crabtree's restrictions, Respondent offered Petitioner a job at the gift shop of the zoo which was to begin on 6/08/2014 (see RX6). Petitioner did not accept this position. Petitioner testified that she did not accept this position as animals are in the lobby and there is a concession stand in the gift shop and only one small little window leading to the outside. Petitioner testified that at the end of June, she moved to Michigan City, Indiana with her mother as her mother was her means of income.

It appears that Petitioner did not seek any medical treatment between May 8, 2014 and September 14, 2014.

Records from Franciscan St. Anthony Health in Michigan City, Indiana note that Petitioner was seen on 9/14/2014 for neck pain/cellulitis of the face. These records make no mention of any pulmonary complaints. On physical examination, Petitioner's pulmonary/chest was interpreted as "effort normal and breath sounds normal." (PX 7)

There is no record of any further medical treatment for Petitioner between September 14, 2014 and December 7, 2014.

Petitioner was seen at Franciscan St. Anthony Health in Michigan City, Indiana on 12/07/2014 with a history of having a cold for three days. Petitioner noted her prior history of chemical exposure and it was recommended that Petitioner establish care with pulmonologist Dr. Dickover. She was diagnosed with an upper respiratory infection and noted to leave the hospital in no acute distress and ambulating with a steady gait. (PX 7)

There are no records of any treatment to Petitioner between December 7, 2014 and April 3, 2015.

Petitioner was seen at Franciscan St. Anthony Health on 4/03/2015 for migraine complaints for the past three weeks. She gave a history of having had "mustard gas exposure" two years previously with reported lung damage and now chronic headaches. Initially the headaches had been 1 – 2 times per week but now, for the last month, they were happening more often. She denied any primary care physician as "she has just moved from Springfield, IL." (PX 7, p. 94) On physical examination, it was noted that Petitioner's pulmonary/chest revealed "Effort normal and breath sounds normal. No stridor. No respiratory distress. She had no wheezes. She has no rales." Petitioner was diagnosed with a headache. (PX7).

Petitioner was under surveillance August 3-4, 2016. On Wednesday, 8/03/2016, Petitioner was seen in the morning going to a pet supply store and a Goodwill store. Later that afternoon, Petitioner was seen going to a Dollar General store, a Family Dollar store, and Wal-Mart. Petitioner was seen smoking throughout the video. Petitioner was seen eating at a McDonald's for approximately one-half of an hour. (RX 3)

On Thursday, 8/04/2016 Petitioner was seen in the morning going to an auto supply store and a gas station. Petitioner was seen exiting the gas station with a pack of cigarettes. Later that date, Petitioner was seen at Indiana Beach Amusement Park located in Monticello, Indiana. (RX 3)

Dr. Tuteur issued a supplemental report on November 21, 2016 after being provided additional records, including ones from Springfield Clinic (10/10/07 – 6/12/13), Dr. Crabtree (5/7/13 – 5/8/14), Cool Spring Health Center (5/15/15), Dr. Dickover dated 6/24/15, a CT scan dated 2/21/07, and a surveillance report dated 8/5/16. He noted that Petitioner's attempts to return to work had been unsuccessful and she had moved to Indiana by 2015 where she established general and pulmonary medical care, reporting intermittent symptoms and the discontinuation of cigarette smoking. Trigger-initiated respiratory symptoms persisted, albeit apparently, at a reduced level of severity. Dr. Tuteur wrote, "No direct comment is made with respect to how fastidiously environmental control was followed." Continued medication with an inhaled corticosteroid, long-acting Beta2 agonists and rescue inhaler was documented. He noted the surveillance video showed that over a two-day period Petitioner smoked a single cigarette and carried a pack of cigarettes and was able to climb an unquantified number of stairs without difficulty. Dr. Tuteur stated that non-compliance with environmental control (particularly lack of complete tobacco smoking cessation) would be likely to adversely affect Petitioner's health status. However, even if cessation were complete it would not resolve the condition of bronchial reactivity. The diagnosis of irritant-induced bronchial reactivity persists. Her diagnosis was noted as irritant-induced bronchial

reactivity a/k/a RADS (reactive airways dysfunction syndrome). He felt it was directly related to her exposure on May 7, 2013. He felt it was quite likely that she had reached MMI in terms of the severity of the underlying bronchial reactivity. He felt there was insufficient data available to identify Petitioner's ability to engage in remunerative activity. She would require an environment where she would not be exposed to triggers that might exacerbate her airways function. "A careful documented history with respect to what currently serves as such triggers and how that might impact employment needs to be determined." With regard to working in an "air conditioned gift shop" the environment still might not be appropriate as patrons could bring to the environment perfumes, colognes, hair sprays, etc. which "may" serve as a trigger to produce bronchoconstriction. The best work environment for Petitioner would be at home, where she would be able to control the ambient space. (PX 5)

Dr. Peter Tuteur testified via an evidence deposition on 12/08/2016. Dr. Tuteur is a board certified pulmonary specialist. He saw Petitioner for an independent medical evaluation at Respondent's request on 8/29/2013. Subsequently, he received a report covering the first two days of surveillance on Petitioner. As part of his evaluation, he reviewed medical records and performed a pulmonary function test and a Methacholine Challenge test. The pulmonary function study was normal at its baseline that worsened during exercise. The Methacholine Challenge test was markedly positive. It was Dr. Tuteur's opinion that Petitioner suffered from chemically-induced bronchial reactivity which he causally related to the 5/07/2013 exposure at work. Regarding treatment, Dr. Tuteur recommended medication and environment control to minimize the episodes of triggers that exacerbate Petitioner's condition. Regarding work status, Dr. Tuteur testified that Petitioner should work in an environment which would prevent her from being exposed to conditions and agents that trigger an exasperation. He did not feel she could return to work as a janitor because she would, no doubt, be exposed to a variety of cleaners that would likely trigger an exacerbation. Dr. Tuteur testified that Petitioner could work as long as the environment was free from those triggering agents. Petitioner advised Dr. Tuteur that her triggers include perfumes, colognes, hairsprays, chemical smells, and high heat and humidity. Dr. Tuteur testified that in order to avoid the triggers, the ideal work would be home-based in which Petitioner could control her environment. Dr. Tuteur did not believe that the gift shop position, or any retail position, was appropriate as Petitioner would be exposed to perfume, cologne, and cleaning agents. Dr. Tuteur agreed that he did not perform any tests to determine if the triggers that Petitioner identified actually exacerbated her condition. He agreed that when Petitioner was seen by Dr. Dickover the doctor's notes don't contain rigorous documentation regarding any history of triggers and their relative potency. He agreed that there was a history of triggers but no current list or indication of Petitioner's triggers and he further agreed her triggers could change. He acknowledged she could do telemarketing out of her home. He felt she had reached maximum medical improvement in 2013 but had no current opinion on that. (PX8).

There is no record of any treatment to Petitioner between April 3, 2015 and July 26, 2017.

Petitioner was under surveillance between May 13 – May 15, 2017. She was seen traveling with a male to a Burger King drive-thru, a Dollar Tree, and a Family Dollar store before returning home. Petitioner was seen leaving a Dollar Tree store with a container of laundry detergent. After getting into the vehicle, Petitioner was seen smoking. Petitioner then went to a Family Dollar store and a cigarette discount store. (RX 3)

On Monday, 5/15/2017 Petitioner was seen walking two children to a nearby school (RX3). Petitioner was observed smoking. (RX 3)

Dr. Molina's records indicate that Petitioner presented to his office on July 26, 2017 to get established for breathing issues. Petitioner underwent a chest x-ray that was interpreted as being normal. Petitioner noted that

for the past month, she had used her Nebulizer more and felt that her lungs had been worse. Petitioner was prescribed Prednisone and advised to follow up in one month. (PX 10)

Petitioner was next seen by Dr. Molina on 10/04/2017. Petitioner reported complaints of left-sided chest pain and mid to upper back pain. Petitioner also noted that she continued to have a cough and wished to see a pulmonologist. Petitioner noted that she saw Dr. Dickover a couple of years earlier, but did not care for him. Petitioner was referred to a pulmonologist. The record states "Had exposure to bleach from her previous work. She blames her breathing issues on that although she did smoke for about 20 years." (PX 10)

Petitioner was last seen by Dr. Molina on 11/01/2017. The history in that record states "Laura Caponigro 41 y.o. female who is here today for several issues. She states that she has had a lot of stress over the past few months. She is going through a lawsuit against a former employer and she is very nervous about it." Petitioner also reported a continued cough. Petitioner reported that she started smoking again due to stress. The physical examination of Petitioner's pulmonary/chest was interpreted as "Effort normal and breathe sounds normal. No accessory muscle usage. No apnea and no tachypnea. No respiratory distress. She has no decreased breath sounds. She has no wheezes. She has no rhonchi. She has no rales." Petitioner was prescribed Duo-Neb and it was noted that Petitioner had an appointment with a pulmonologist in December (PX10).

Dr. David Crabtree testified via an evidence deposition on 6/19/2017. Dr. Crabtree is a board certified pulmonary specialist. He was Petitioner's treating pulmonologist from 6/08/2013 – 5/08/2014. As a result of the 5/07/2013 incident, Dr. Crabtree testified that Petitioner sustained reactive airway dysfunction syndrome (RADS) or some persistent airway reactivity. Dr. Crabtree testified that what was questionable was how bad Petitioner's symptoms are from the RADS. When Dr. Crabtree last saw Petitioner on 5/08/2014, based on the peak flow meter, he did not see that Petitioner was having any symptoms. Dr. Crabtree testified that RADS is usually not a permanent process. What perplexed Dr. Crabtree was that Petitioner continued to have symptoms when, normally, the lungs would heal. Petitioner's persistent complaints did not fit the typical pattern of RADS. Dr. Crabtree testified that Petitioner would need to continue to take her prescription medication until the time when she has no symptoms and it is proven by a pulmonary function test that she is no longer reactive to different things. Dr. Crabtree testified that smoking alone could cause a permanent bronchi reactivity. The last time that Dr. Crabtree saw Petitioner on 5/08/2014, he felt that Petitioner's description of her symptoms was out of proportion to the objective findings. Dr. Crabtree testified that he did not see findings similar to Petitioner's complaints based on his exam, chest x-ray and pulmonary function testing. Based on the peak flow test, Petitioner's symptoms were out of proportion to any kind of physical findings. Dr. Crabtree testified that the peak flow meter findings document that some of Petitioner's symptoms were not lung-related. Dr. Crabtree further testified that while Petitioner indicated that she had quit smoking, the test that he performed did not support this. Regarding Petitioner's work status, Dr. Crabtree opined that Petitioner could work. He testified that this would be a trial and error process. Dr. Crabtree testified that any job that did not require exposure to cleaning chemicals would be okay and safe for Petitioner (RX2).

Petitioner's case proceeded to arbitration on November 9, 2017. The disputed issues were causal connection, temporary total disability benefits, and the nature and extent of Petitioner's injury. (AX 1) Derek Harms was present as Respondent's representative. Witnesses testifying at the hearing were Petitioner, Edward Pagella, Susan Caponigro, and Derk Harms.

Mr. Edward Pagella testified on behalf of Petitioner. Mr. Pagella is a licensed vocational rehabilitation consultant. At the request of her attorney, Mr. Pagella met with Petitioner on 1/09/2017 to perform a vocational assessment. As part of his assessment, Mr. Pagella reviewed the medical records of Central Illinois Allergy and Respiratory Clinic, Memorial Medical Center, Franciscan St. Anthony Health, St. John's Hospital, Dr. Drapezia,

Dr. Crabtree and Barnes-Jewish Hospital. Mr. Pagella also reviewed the deposition of Dr. Peter Tuteur. Subsequent to the meeting, Mr. Pagella generated a report (See PX9). After reviewing the medical information, Mr. Pagella testified that it was his professional opinion that based on the restrictions imposed, Petitioner would be relegated to a position working in a controlled environment in her home. It was Mr. Pagella's opinion that a labor market does not exist for a home-based job for Petitioner since she is qualified for an unskilled occupation. On cross-examination, Mr. Pagella agreed that he did not review the deposition of Dr. David Crabtree. Mr. Pagella was not aware of how long Dr. Crabtree had treated Petitioner. Mr. Pagella testified that he was not aware of what specialty Dr. Crabtree practiced in. Mr. Pagella was not aware that Dr. Crabtree, in his record, stated "Her description of her symptoms are out of proportioned to the objective findings we have had for her all along," nor was Mr. Pagella aware that Dr. Crabtree, in his record, stated "By no means do I feel that this lady would be permanently and totally disabled." Mr. Pagella agreed that when he interviewed Petitioner, he asked her how she was doing and she indicated that she avoided people and any type of chemicals. Mr. Pagella testified that his causation opinion was not based on the honesty of these statements. His understanding was that Petitioner was honest with him with she discussed the triggers and how she avoids people. Mr. Pagella testified that he was not aware of the Springfield Park District. Lastly, Mr. Pagella testified that he was not aware if Petitioner worked full or part-time for the Park District.

Petitioner testified that she started working for Respondent in the spring of 2011. She worked part-time as a maintenance worker performing cleaning duties. Wage records reflect that in May of 2013, Petitioner was working approximately 17 hours per week at a rate of $8.25/hour (RX1).

Petitioner further testified that on May 7, 2013 the Nelson Center manager asked Petitioner to clean the locker rooms in preparation for the opening of the pool season. As Petitioner was cleaning the urinals, she poured bleach into them. Subsequently, Petitioner testified that a cloud of smoke developed and she felt like she could not breathe. Petitioner testified that she immediately stepped outside to get some fresh air which made her breathing worse. Petitioner then proceeded into her manager's office who advised the director of the Nelson Center to take her immediately to the emergency room.

Petitioner testified to her medical care as reflected in the medical records noted above. She further testified that she returned to work for Respondent on December 6, 2013 working at the Nelson Center answering phones. On March 4, 2014, Petitioner returned to see Dr. Crabtree and was taken off work.

Petitioner testified that she continued to treat with Dr. Crabtree through May 8, 2014. Around that time Respondent offered her a position in the gift shop of the Park District Zoo. Petitioner acknowledged that she did not report to work at the zoo as instructed. She explained that the gift shop is located right there in the lobby and there are animals right there. She further pointed out that there is only one small little window in the gift shop.

Petitioner further testified that towards the end of June in 2014 she moved to Michigan City, Indiana because her mother was going there and she was Petitioner's means of income. Petitioner's mother was the sole means of support for Petitioner and her children after the exposure. Petitioner further testified that she has received treatment at the Franklin Clinic and Franciscan St. Anthony Health. She currently treats with Dr. Molina. He first saw her on July 16, 2017.

Petitioner testified that at the time of the hearing her chest has been hurting "very heavy." Her nebulizer medicine had been increased to a higher dosage because of her breathing and she sleeps in a recliner chair because she can't lie flat due to the inability to breathe.

Petitioner testified that every day activities are getting worse for her. Petitioner testified that she is now homebound, although she does push herself to go out and do things with her children as her abilities allow. Petitioner testified that she still smokes because the stress gets to her. Petitioner testified that when she is around people with cologne, she cannot breathe. Petitioner testified that prior to this incident, she had no problems with her lungs and breathing. Petitioner acknowledged that her mother smokes but not in the house. There are also pets- dogs, a rabbit and a guinea pig. Petitioner testified that she doesn't wear cologne or perfume nor does anyone in the house. Petitioner also testified that when she was in the bathroom at the hearing site she had to keep her face in her shirt because there was a body spray in the bathroom that someone had sprayed and it was very strong and she couldn't breathe.

Petitioner denied any problems with her lungs and breathing before her exposure.

On cross-examination, Petitioner identified RX9 as Facebook postings of herself and her daughter or son. The first entry notes that on 12/19/2013 Petitioner attended a football game in St. Louis at the dome on 11/24/2013 with her boyfriend. During this time, Petitioner was receiving temporary total disability benefits. An entry from 11/12/2014 states that "Way too early to be up waiting on a train!! But well worth it. I get to visit my amazing friend." An entry from that same date states "Getting ready to go out!! #girlsnightout #lovemylife #anythingcanhappenlol." Petitioner testified that the only reason that she took a train was to come to court. Petitioner stated that she did not post this and that she did not go out anywhere. Petitioner testified that it may have been her daughter posting this. Petitioner's daughter would have been 10 years old on that date. Petitioner did not understand why it stated the train as she only took the train to go to court. An entry from 7/03/2016 states "Happy Fourth of July. Getting our buckets of drink on. Cheryl Sanchez." Petitioner testified that this was at her aunt's yard in LaPorte, Indiana. Petitioner testified that the only time that she took the train was to go to court. Petitioner testified that she would not take the train to Chicago to visit friends. An 8/01/2016 entry states "Six more days and I am heading to Chicago for some much needing relax and drinking time." Petitioner did not know how that entry got there. Petitioner testified that she was sure she was heading to Chicago to her grandmother's house. An 8/04/2016 entry notes that Petitioner was on her way to Indiana Beach, a water park. Petitioner was aware that surveillance video showed her at the water park. Petitioner testified that she went there for her children. The next entry is from 8/07/2016 and states "Chicago here I come with Mercedes Smith and Larry Lilbird." Petitioner testified that that is her brother and his fiancé. Petitioner testified that her brother drove her to Chicago to get something to eat on Maxwell Street while she stayed in the car. An entry from 9/15/2016 notes that Petitioner was on her child's class trip to the County Line Orchard. Petitioner testified that she was able to control everything she did in that situation. A 10/09/2016 entry states that "On our way back home. Had a great time with friends and family for my cousin Jaclyn Sanchez's baby shower!" Subsequent entries from October 10 and October 12, 2016 note that Petitioner attended her daughter's volleyball games. Petitioner testified that the volleyball games are played at a big gymnasium. An entry from 10/23/2016 notes that Petitioner drove to Michael Jackson's house in Gary, Indiana (RX9).

Petitioner's mother testified on Petitioner's behalf. Petitioner's mother testified that she lives with her daughter and son and Petitioner's two children. Petitioner's mom testified that she quit smoking almost two months ago. Petitioner's mom testified that she had to change cleaning fluids due to her daughter's condition. Petitioner's mom testified that her daughter sleeps upstairs in her bedroom. Petitioner's mom testified that her son quit smoking almost four months ago.

Mr. Derek Harms testified on behalf of Respondent. Mr. Harms testified that he has worked for the Park District for 10 ½ years. For the first 4-5 years, he worked as the director of recreation, overseeing all of the recreation programs and facilities including the Nelson Center. For the last 5 years, he has worked as the executive director of the Springfield Park District. Mr. Harms testified that the park district is one of the largest

park districts in the state of Illinois. The Springfield Park District employs 90 full time workers and anywhere from 100 to 400 part-time workers. The Springfield Park District offers dozens of recreational facilities throughout the community. The Nelson Center has two sheets of ice. There are four golf courses, botanical garden, the Carillon, a zoo, a rental center, tennis center, preschools, a fun shop facility and outdoor opportunities. The Springfield Park District consists of 35 parks and 2,500 acres of land.

As the executive director, Mr. Harms testified that he is aware of the Park District's policy about accommodating work restrictions. Mr. Harms testified that the Park District does everything it can to put people back to work. Mr. Harms testified that this is important to the Park District and they have a long history of doing this. Mr. Harms testified that they are very unique and that the diversity of the Park District allows them to have a lot of opportunities for providing different types of employment to work with the restrictions. Mr. Harms testified that he heard Petitioner testify about her apprehension of working at the gift shop of the zoo. Mr. Harms testified that they certainly would have been able to offer other opportunities for her to return to work if the zoo position did not work. Examples of other opportunities include at the administrative office which is located at the Bunn Golf Course and is a controlled environment. At the administrative office, they have a lot of filing work on a regular basis and a lot of mailings that need to be performed. Mr. Harms testified that they have a lot of facilities where they need assistance in the front of the shop or helping out with administrative functions. A sales representative at Erin's Pavilion is needed to make calls. With over 2,500 acres of parks, the Park District needs assistance in permitting to the public, renting out picnic shelters or baseball fields. Mr. Harms testified that it would be a trial by error to see what works with all of these opportunities.

The Arbitrator concludes:

1. **Credibility.** Petitioner's credibility in this case was significantly compromised. The Arbitrator notes that Dr. Crabtree consistently documented that Petitioner's subjective complaints were not supported by his objective findings. Petitioner testified that as a result of the 5/07/2013 chemical exposure, she has been essentially homebound as she attempts to avoid any triggers that would exasperate her condition. This testimony, however, was strongly contradicted by the surveillance video and Petitioner's social network postings. The surveillance video and social network postings document that Petitioner was very active and showed no signs of limiting her activities to avoid potential triggers. Petitioner's activities include eating in a public restaurant, shopping, attending a water park and attending a sporting event with tens of thousands of people. The Arbitrator specifically notes Petitioner's responses and lack of credibility when surprised with her social network postings at trial.

   The Arbitrator also finds it significant that Petitioner claims difficulty being around perfumes, colognes, and sprays. The trial of this case lasted approximately 1.5 hours and was held in a fairly small hearing room at the Springfield IWCC offices. Throughout the proceeding, the windows were closed as were the doors. In addition to the Arbitrator and the court reporter there were two attorneys, Petitioner and Mr. Harms present throughout the hearing. In addition, several witnesses came in and out of the room to testify. No request was made prior to the hearing that those in attendance refrain from using perfume, cologne, hair spray, chemical smells, and high heat and humidity. Petitioner was in close proximity to the Arbitrator who, herself, was wearing hairspray. At no time during the hearing did Petitioner show any signs of having problems with breathing. While she testified to entering the public restroom and having trouble due to a body spray, she displayed no lingering signs of difficulty or problems from that alleged earlier episode. Furthermore, there were other claimants and attorneys outside the hearing room and Petitioner was around them prior to the hearing and, yet, reported no

problems. All of the foregoing, significantly comprises Petitioner's credibility in this matter and casts suspicion on her motivation.

2. **Causal Connection**. The Arbitrator finds that Petitioner failed to prove that her current condition of ill-being is causally connected to the May 7, 2013 accident. The Arbitrator notes the significant gap in medical treatment since May/June of 2014. The Arbitrator finds it suspect that Petitioner resumed medical treatment months before trial. During the gap in medical treatment, Petitioner continued to smoke. The Arbitrator notes Dr. Crabtree's opinion that if Petitioner was consistently smoking, she could cause a permanent issue with the bronchi reactivity solely from smoking. The Arbitrator also notes Dr. Molina's entry during his 10/04/2017 exam when he noted "She blames her breathing issues on her bleach exposure despite her smoking for many years." No doctor testified that Petitioner's current condition of ill-being is causally related to her 2014 exposure/accident. In light of a lack of current causation opinion, significant gaps in treatment, and Petitioner's significant credibility issues, the Arbitrator finds that Petitioner failed to prove that her current condition since her last visit with Dr. Crabtree in May of 2014 is a result of the May 7, 2013 exposure. The Arbitrator finds that Respondent has no obligation to pay for any additional medical treatment.

3. **Temporary Total Disability Benefits**. The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from 6/17/2013 – 12/05/2013 and 3/04/2014 – 6/07/2014 or 38 weeks at a rate of $142.00 or $5,396.00. Petitioner's refusal to accept Respondent's offer of light duty was not reasonable. Additionally, the Arbitrator finds Mr. Derek Harms' testimony regarding restrictive duty accommodations to be credible.

4. **Permanent Partial Disability**. The Arbitrator finds that Petitioner failed to prove that she is permanently and totally disabled as a result of the 5/07/2013 exposure/accident. This finding is based on multiple factors including Petitioner's lack of credibility, Petitioner's refusal to even attempt Respondent's offer of employment, the surveillance video and Petitioner's social network pages contradicting Petitioner's testimony that she needs to avoid numerous triggers that exasperate her condition, Petitioner's lack of looking for work, and the testimony of Dr. Crabtree.

   While Mr. Pagella, Petitioner's vocational expert, testified that there is no stable labor market for Petitioner since she needs to be confined to her home in order to work, he did not have a complete understanding of the nature of Petitioner's injury. Indeed, no one really does. Mr. Pagella, Dr. Tuteur and Dr. Crabtree have all relied upon Petitioner's representations to them as to what triggers her breathing problems. However, no one has independently determined/identified, through proper medical testing, what her exact triggers are. Based upon significant credibility and motivational concerns regarding Petitioner, the Arbitrator finds Petitioner's representations as to what triggers her problems very self-serving. Dr. Tuteur agreed that he did not perform any tests to determine if the triggers that Petitioner identified actually exacerbated her condition. He agreed that when Petitioner was seen by Dr. Dickover the doctor's notes don't contain rigorous documentation regarding any history of triggers and their relative potency. He agreed that there was a history of triggers but no current list or indication of Petitioner's triggers and he further agreed her triggers could change. In his report issued just prior to his deposition he stated that there was insufficient data available to identify Petitioner's ability to engage in remunerative activity. She would require an environment where she would not be exposed to triggers that might exacerbate her airways function. "A careful documented history with respect to what currently serves as such triggers and how that might impact employment needs to be determined." (PX 5) Even Dr. Crabtree felt identifying the triggers would be a trial and error process.

In the end, no doctor has objectively identified, absent perhaps the offending bleach agent, what triggers bring on Petitioner's symptoms. Mr. Pagella's opinion are not based upon a thorough knowledge and understanding of Petitioner's situation and what triggers the breathing problem. He did not consider the video surveillance, Facebook postings, and/or the possibility that Petitioner's representations to him as to her triggers had not been medically tested and documented. He was unaware of, and did not consider, the testimony of Petitioner's treating physician, Dr. Crabtree. Again, Petitioner's credibility compromises anything she told Mr. Pagella and, in turn, his opinions derived therefrom.

Petitioner did have an exposure, sustained an acute lung irritation, and suffers from chemical induced bronchial hyperactivity (or RADS). She is not, however, totally and permanently disabled as a result of that exposure. As such, permanency will be addressed pursuant to Section 8.1b of the Act.

Pursuant to Section 8.1b of the Act, for accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to the 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) the 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

With regard to Section 8.1b(b)(i) of the Act, no impairment rating was introduced by either party. Therefore, this factor is given no weight.

With regard to Section 8.1b(b)(ii) of the Act, Petitioner is currently not employed. Petitioner was given restrictions by Dr. Crabtree that Respondent was attempting to accommodate. Petitioner did not engage in reasonable and good faith efforts to try and see if an accommodation could be had. Additionally, she voluntarily removed herself from Respondent's employment by moving to Indiana. Again, citing significant credibility issues with Petitioner, the Arbitrator does not find Petitioner's current unemployment to be the result of her exposure/accident herein. While there are probably some chemicals/triggers that Petitioner should avoid (bleach) no definitive effort has ever been undertaken

to identify those triggers. Dr. Tuteur's recommendation was to avoid those situations where she would be exposed to people and conditions she could not control. However, it appears he had no idea of Petitioner's true level of activity and ability to be outside her home without any apparent triggers or need for medical attention. The surveillance video, Facebook information, and Petitioner's lack of treatment for approximately three years does not paint the picture of a claimant so ill from an exposure that she is completely unable to work. Dr. Tuteur only examined Petitioner on one occasion whereas Dr. Crabtree had a longer doctor/patient relationship with Petitioner. Dr. Crabtree's records show that when he last Petitioner her description of her symptoms was out of proportion to his objective findings. He did not feel she was permanently, totally disabled His list of triggers to avoid was very small and did not require Petitioner to stay a prisoner in her home (which she apparently isn't). Those triggers have also included not being around smoke which Petitioner has not been able to adhere to. Petitioner's motivation in turning down the job at the gift shop and her failing to engage in other efforts at accommodation is highly suspect. In the end, the Arbitrator does not find Petitioner's unemployability to be due to her work accident. Therefore, the Arbitrator gives little weight to this factor.

With regard to Section 8.1b(b)(iii) of the Act, Petitioner was 37 years old at the time of the injury. Petitioner is a younger individual and her permanent partial disability will be moderately greater than that of an individual since Petitioner will have to live with the consequences of her injury for a longer period of time. The Arbitrator gives some weight to this factor.

With regard to Section 8.1b(b)(iv) of the Act, Petitioner is not working. The Arbitrator does note that at the time of the accident/exposure, Petitioner had an average weekly wage of $142.00. The Arbitrator does not feel Petitioner's future earning capacity has been impacted as a result of her injury herein. This factor is given little weight.

With regard to Section 8.1b(b)(v) of the Act, the Arbitrator notes that most of Petitioner's medical treatment was with her treating pulmonologist, Dr. Crabtree from 6/18/2013 – 5/08/2014. During this period, Dr. Crabtree did document signs of an acute inhalation injury. However, also during this time period, Dr. Crabtree was confused by Petitioner's response to treatment and documented that Petitioner's subjective complaints did not match his objective findings.

Petitioner has undergone very little treatment since leaving Springfield, Illinois, in June of 2014. Petitioner's testimony as to her current problems and symptoms was not entirely credible.

Based on the weighing of these factors, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of the person as a whole.

5. **Medical Bills.** Per the stipulation of the parties, Respondent is ordered to satisfy the Illinois Department of Healthcare and Family Services' lien in the amount of $534.56 as reflected in PX6. As noted above, Respondent has not obligation to pay any additional medical bills.

6. **Credit.** Respondent is entitled to a total credit of $7,936.56 representing temporary total disability benefit payments in the amount of $5,436.56 and a $2,500.00 permanent partial disability advance.

****

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

Mark McDannald,

Petitioner,

vs. NO: 14 WC 28454

County of Peoria,

18IWCC0463

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 November 27, 2017 is hereby affirmed and adopted.

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

No bond is required for 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: JUL 25 2018
SJM/sj
o-7/12/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McDANNALD, MARK
Employee/Petitioner

Case# **14WC028454**

COUNTY OF PEORIA
Employer/Respondent

18IWCC0463

On 11/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% 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:

0225 GOLDFINE & BOWLES PC
KEVIN ELDER
4242 N KNOXVILLE AVE
PEORIA, IL 61614

5354 STEPHEN KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

18IWCC0463

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

Mark McDannald
Employee/Petitioner

v.

County of Peoria
Employer/Respondent

Case # 14 WC 28454

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 October 19, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On January 4, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $61,609.60; the average weekly wage was $1,184.80.

On the date of accident, Petitioner was 53 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 $4,644.81 for other benefits, for a total credit of $4,644.81.

Respondent is entitled to a credit of $26,352.70 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

November 18, 2017
Date

ICArbDec p. 2

NOV 27 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on January 4, 2014. According to the Application, "Petitioner fell out of truck" and sustained an injury to the "Left lower extremity & man as a whole" (Arbitrator's Exhibit 2). Respondent stipulated that Petitioner sustained a work-related injury on January 4, 2014; however, Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in 1994 and was a laborer. Petitioner's job duties varied and he did road maintenance, tree trimming, removal of debris and, during the winter months, operated a truck/snow plow. Petitioner testified that during the winter months, he worked on the night shift. He stated that his job duties were much more physically demanding in spring/summer months when he was on the day shift.

On January 4, 2014, Petitioner was in the process of getting out of the truck and he put his right foot on one of the steps. Because the step had an accumulation of ice on it, Petitioner's right foot slipped off of the step which caused his right foot to forcefully hit the ground. Petitioner testified that this also caused him to sustain what he described as a hyperextension type injury to his left hip. Petitioner stated that the truck cab was four feet off of the ground and had two steps leading up to it, with the third step being the one in which the individual would enter into the cab.

Petitioner stated that at the time of the accident he experienced right heel pain and some soreness/tightness in his left hip. Petitioner completed and signed an "Employee Statement" which described the accident of January 4, 2014, as occurring when Petitioner was "...getting out of truck slipped on step and fell on right foot". The injury was described as "foot sore." There was no reference to Petitioner having sustained an injury to his left hip (Respondent's Exhibit 5).

A "Report of Accident Investigation" was prepared and signed by Randy Gunner (who Petitioner testified was his supervisor), which described the accident of January 4, 2014, and that Petitioner slipped on a step of a truck and fell on his right foot. There was no reference to Petitioner having sustained an injury to his left hip (Respondent's Exhibit 6).

An "Employer's First Report of Injury" was also prepared which described the accident of January 4, 2014. The information in that report was consistent with the other reports as it noted Petitioner slipped on a step while getting out of a truck and sustained an injury to his right foot. Again, there was no reference to Petitioner having sustained an injury to his left hip (Respondent's Exhibit 1).

Petitioner did not seek any medical treatment immediately following the accident. It was sometime in February, 2014, when Petitioner went to an ER because of right foot symptoms. The record of that ER visit was not tendered into evidence at trial.

Petitioner stated he continued to work, but when he was on the night shift, he only noticed a little bit of tightness in his left hip. In early April, 2014, Petitioner switched to working the day shift which, as aforestated, was more physically demanding than the night shift. At that time, Petitioner said he began to experience more pain and tightness in his left hip.

In mid-April, Petitioner discussed his left hip issues with his supervisor, Randy Gunner. Gunner sent Petitioner to Illinois Work Injury Resource Center (IWIRC) where he was initially seen on April 28, 2014. According to the IWIRC record, Petitioner sustained an injury in mid-January when he was getting out of a tandem truck after plowing snow. Petitioner put his right foot on a step of the truck and fell hitting his left buttock and upper leg on the steps and landed on the ground (Respondent's Exhibit 10).

Petitioner was diagnosed with a lumbar muscle strain and left hamstring injury. He was treated conservatively with medication and physical therapy. When seen by Dr. Daniel Stopka on May 13, 2014, it was noted that Petitioner's left hip symptoms had not improved. Dr. Stopka opined Petitioner had left sacroiliitis without change in symptoms since the initial injury four months ago (Respondent's Exhibit 10).

Petitioner was subsequently seen at IWIRC on May 28, 2014, by Chelsea Hart, a Physician Assistant. Petitioner's lumbar strain had resolved; however, PA Hart reviewed x-rays of the left hip which revealed severe degenerative joint disease which she opined was not work-related (Respondent's Exhibit 10).

Petitioner sought treatment for his left hip condition from Dr. Brad Roberts, an orthopedic surgeon. Dr. Roberts initially evaluated Petitioner on June 18, 2014. According to Dr. Roberts' record of that date, Petitioner complained of left hip pain that occurred after he fell out of a truck in January. Petitioner was using his left foot to get into the truck and, as he pushed forward, he slipped and fell to the ground. Dr. Roberts opined Petitioner had left hip pain post accident falling out of a truck in January, 2014, and advanced osteoarthritis of the left hip. In regard to causality, Dr. Roberts noted the degenerative changes would have been present in the left hip prior to the accident, but he noted "It is likely that his injury back in January exacerbated discomfort stemming from arthritic changes in his hip." (Respondent's Exhibit 11).

Petitioner was subsequently seen by Dr. Amod Sureaka, an orthopedic surgeon associated with Dr. Roberts. Dr. Sureaka administered injections in Petitioner's left hip on July 1, and August 18, 2014.

At the suggestion of a coworker, Petitioner was seen by Dr. Richard Driessnack, an orthopedic surgeon, on October 10, 2014. According to Dr. Driessnack's record of that date, Petitioner sustained the injury in January, 2014, when he was getting out of the snow plow truck when his foot slipped while descending the truck and Petitioner did the "splits." As a result of this accident, Petitioner strained his left hip. Dr. Driessnack noted Petitioner's prior treatment and opined a hip arthroplasty was appropriate. However, Dr. Driessnack noted Petitioner's BMI was too high and Petitioner needed to lose about 40 pounds before undergoing surgery (Petitioner's Exhibit 3).

Petitioner was able to lose the weight and Dr. Driessnack performed a total arthroplasty of the left hip on January 19, 2015. Dr. Driessnack treated Petitioner following the surgery and ordered physical therapy. When Dr. Driessnack saw Petitioner on April 10, 2015, he authorized Petitioner to return to work without restrictions on April 15, 2015 (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Lawrence Li, an orthopedic surgeon, on February 8, 2016. In connection with his examination of Petitioner, Dr. Li reviewed medical records and the First Report of Injury provided to him by Respondent. Dr. Li opined Petitioner had osteoarthritis of the left hip and that the surgery performed was appropriate. In regard to causality, Dr. Li opined that the medical documentation did not support a causal relationship between the accident and the osteoarthritis in Petitioner's left hip. Dr. Li specifically noted Petitioner did not report any left hip pain until months after the accident (Respondent's Exhibit 2).

At the direction of his attorney, Petitioner was examined by Dr. Alexander Cummings, an emergency medicine and pain management physician, as well as a cosmetic surgeon, on October 27, 2016. In connection with his examination of Petitioner, Dr. Cummings reviewed medical records provided to him by Petitioner's counsel. Dr. Cummings opined Petitioner sustained a strain/sprain of the left hip which acutely exacerbated the underlying arthritis which ultimately led to hip surgery (Petitioner's Exhibit 1; Deposition Exhibit 2).

Dr. Cummings was deposed on April 14, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Cummings' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to the accident, Dr. Cummings testified that Petitioner informed him that following the accident, his right foot was hurting more than the left hip and that, because he was on the night shift, he was not doing much strenuous activity. It was about a week and a half after Petitioner went to the day shift that his left hip started to hurt more. Dr. Cummings stated Petitioner had a degree of arthritis in both hips, but that the accident exacerbated the arthritic condition in his left hip which ultimately led to surgery. He also stated that Petitioner's delay in seeking treatment did not break the causal connection because the injury started the inflammatory process which became more symptomatic when Petitioner started doing more physically demanding activities (Petitioner's Exhibit 1; pp 11, 16-19).

On cross-examination, Dr. Cummings agreed he could not objectively state to what degree the accident aggravated the arthritis in Petitioner's left hip. He also conceded that he could not determine to what extent the degenerative changes were present on January 3, 2014 (Petitioner's Exhibit 1; pp 31-32).

Dr. Li was deposed on July 17, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Li's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to causality, Dr. Li testified the accident of January, 2014, did not contribute to Petitioner's left hip osteoarthritis. He stated that Petitioner's hitting his buttock on the truck would not accelerate the osteoarthritis, but that the condition could be aggravated by months and years of repetitive trauma (Respondent's Exhibit 3; pp 17-18).

On cross-examination, Dr. Li agreed Petitioner had no prior treatment for left hip symptoms. He also had no knowledge as to whether Petitioner had osteoarthritis in his right hip or not, but stated it can appear both unilaterally and bilaterally (Respondent's Exhibit 3; pp 25-29).

At trial, Petitioner testified he was able to return to work to his regular job for Respondent and has continued to work in that capacity. Petitioner stated he is very careful about how he moves, getting in/out of the truck, climbing up/down hills, etc. Because of his left hip condition, kneeling/crawling is now more difficult than what it was prior to the accident. Petitioner had no complaints in regard to his right foot.

Conclusions of Law

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

The Arbitrator concludes Petitioner's current condition of ill-being in regard to his left hip is not causally related to the accident of January 4, 2014.

In support of this conclusion the Arbitrator notes the following:

In the "Employee Statement" which Petitioner completed and signed shortly after the accident, he only described having sustained an injury to his right foot. There was no reference to Petitioner having sustained an injury to his left hip.

In both the "Report of Accident Investigation" and "Employer's First Report of Injury," the only injury described was to Petitioner's right foot. There was no reference to Petitioner having sustained a left hip injury.

Petitioner's testimony that his left hip symptoms became more intense after he went back to the more physically demanding day shift might be credible if he had, in fact, reported some type of injury to his left hip shortly after he sustained the accident and that his left hip symptoms had gotten more intense after he returned to work on the day shift.

At trial, Petitioner testified he injured his left hip when his right foot slipped which caused him to sustain a hyperextension type injury to his left hip.

Petitioner did give a consistent history of how he sustained a left hip injury when evaluated by Dr. Driessnack on October 10, 2014, stating that he did the "splits."

However, in the history Petitioner provided to IWIRC on April 28, 2014, he stated he struck his left buttock and upper leg on the steps when he fell.

In the history Petitioner provided to Dr. Roberts on June 18, 2014, he stated that he fell while getting into the truck. As noted herein, the histories Petitioner provided to the other medical providers was that he fell while getting out of the truck.

The preceding clearly indicates that Petitioner provided inconsistent histories as to exactly how he sustained the injury to his left hip.

Both Petitioner's Section 12 examiner, Dr. Cummings, and Respondent's Section 12 examiner, Dr. Li, agreed Petitioner had pre-existing osteoarthritis in the left hip.

Dr. Cummings' opinion that the accident exacerbated the osteoarthritis in Petitioner's left hip is not persuasive given Petitioner's failure to report a left hip injury and the delay in seeking medical treatment.

Dr. Li's opinion that there was not a causal relationship between Petitioner's left hip condition and the accident is consistent with Petitioner's failure to report an injury to his left hip and the delay in seeking treatment.

The Arbitrator finds Dr. Li's opinion to be more persuasive than that of Dr. Cummings.

In regard to disputed issues (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (F).

William R. Gallagher, Arbitrator

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

Gary A. Jones,

Petitioner,

18IWCC0464

vs.

No. 13 WC 09600

Brian Moreman d/b/a Moreman's Home Improvement, and
Illinois State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

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

The Commission does not adopt the Arbitrator's findings that Moreman was not operating under and subject to the provisions of the Act, or that an employment relationship did not exist between Petitioner and Moreman. The Commission affirms the denial of the claim for failure to prove a repetitive trauma.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 21, 2017, is hereby affirmed and adopted with changes.

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.

18IWCC0464

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: JUL 25 2018
o-07/12/2018
SM/sk
44

Stephen Mathis

David L. Gore

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES, GARY A
Employee/Petitioner

Case# **13WC009600**

BRIAN MOREMAN D/B/A MOREMAN'S HOME IMPROVEMENT/IWBF
Employer/Respondent

18IWCC0464

On 11/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% 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:

1551 STOKES LAW OFFICES
JACOB R JACKSON
200 N GILBERT
DANVILLE, IL 61832

1937 TUGGLE SCHIRO LICHTENBERGER
TODD D LICHTENBERGER
510 N VERMILION
DANVILLE, IL 61832

1368 ASSISTANT ATTORNEY GENERAL
CHRISTINA SMITH
500 S SECOND ST
SPRINGFIELD, IL 62706

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

18IWCC0464

☒ 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

GARY A. JONES
Employee/Petitioner

Case # 13 WC 009600

v.

Consolidated cases: N/A

BRIAN MOREMAN d/b/a MOREMAN'S HOME IMPROVEMENT/IWBF
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **September 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings? (only an issue as to Respondent IWBF)
H. ☐ What 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? (only an issue as to Respondent Moreman)
N. ☐ Is Respondent due any credit?
O. ☒ Other **Admissibility of Petitioner's Exhibit 8 and Respondent Moreman's Exhibit 1**

FINDINGS

On **March 11, 2013**, Respondent ***was not*** 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.

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

With respect to Respondent Moreman, in the year preceding the injury, Petitioner earned **$2,813.50**; the average weekly wage was **$255.77**.

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

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

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

ORDER

Petitioner failed to prove that he sustained an accident on March 11, 2013 that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his right hand and arms was causally related to his accident or employment duties for Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

November 16, 2017
Date

ICArbDec p. 2

NOV 21 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner worked for Respondent Moreman between July of 2011 and October 1, 2011 as a roofer. Petitioner was involved in a motor vehicle accident on September 30, 2011. He has not worked since that accident.

Petitioner saw Dr. Ochoa on October 10, 2011, and while the medical note is largely unreadable it does indicate Dr. Ochoa's recommendation of an EMG of the left arm. There is also mention of a three vehicle accident. Petitioner saw Dr. Ochoa again on October 20, 2011, and, again, the note is difficult to read but it does not appear to mention any issues with either upper extremity (PX 1).

Petitioner saw Dr. Tazudeen on November 10, 2011, complaining primarily of neck and back pain related to a motor vehicle accident. Petitioner was a passenger in a truck and sitting in a toolbox when another car spun around hit him in the passenger side. Petitioner was thrown forward with multiple injuries at that time. He was not wearing a seatbelt because he was sitting on the toolbox. He hurt his neck and lower back and was complaining of intense pain in those regions. Petitioner reported that his neck pain radiated to both shoulders and both his upper extremities were going numb. Dr. Tazudeen's impression was a car accident with head and neck injuries, including strains. (PX 2)

Dr. Tazudeen performed an EMG of both upper extremities that same day and the report indicates severe right carpal tunnel syndrome, bilateral cubital tunnel syndrome, and bilateral C5-6 nerve root irritation. (PX 3)

Petitioner returned to Dr. Tazudeen on November 14, 2011, for the results of the EMG and the doctor indicated a finding of bilateral carpal tunnel syndrome. Petitioner was complaining of paresthesia in both upper extremities with neck and shoulder pain radiating to both extremities. The doctor also indicated ulnar nerve compression but does not specify right or left (PX 2)

Petitioner continued to treat with Dr. Ochoa in late 2011. (PX 1)

On October 18, 2011 Petitioner filed an Application for Adjustment of Claim (case # 11 WC 40147) against Respondent Moreman herein alleging neck and back injuries as a result of an accident occurring on September 30, 2011. (AX 2, IWCC records)

Petitioner continued to treat with Dr. Ochoa on November 15, 2011 and December 15, 2011. As of December 15, 2011 Petitioner was waiting on his disability. He was still having severe low back pain radiating to his buttocks and his neck and right carpal tunnel still hurt. (PX 1)

Petitioner also saw Dr. Ochoa on January 13, 2012, February 10, 2012, and March 26, 2012. While the records discuss/reference carpal tunnel syndrome and/or cubital tunnel syndrome, there is no history provided therein suggesting that Petitioner associated his symptoms with his former work duties for Respondent.

While treating with Dr. Ochoa during the early part of 2012 Petitioner also started seeing Dr. Santiago of Christie Clinic. He presented to Dr. Santiago on February 7, 2012 reporting numbness and tingling involving

both hands. He also gave a history of having been involved in a motor vehicle accident on September 30, 2011 when he was non-restrained and riding in the back of a company van that was t-boned by a drunk driver. Petitioner began complaining of immediate neck pain and had been worked up with an EMG, x-rays, and an MRI. Petitioner's symptoms included burning, aching, shooting, and throbbing pain in his neck and shoulder with numbness and tingling in his hands. Petitioner's past medical history included bilateral carpal and cubital tunnel syndrome and rheumatoid arthritis. The physical examination that day showed weakened grip bilaterally, left worse than right, and mildly positive compression sign at the wrists, left worse than right. The doctor acknowledged the earlier EMG study which evidenced carpal tunnel syndrome and cubital tunnel syndrome but did not make any recommendation regarding treatment of those issues. A history of rheumatoid arthritis and osteoarthritis was noted. Extensive rehabilitation was felt to be appropriate with the neck being addressed first. Cervical injections were also discussed. (PX 4)

Petitioner continued to treat with Dr. Ochoa on April 24, 2012, May 21, 2012, June 19, 2012, July 18, 2012, August 17, 2012, and September 7, 2012. (PX 1), and November 1, 2012, do not appear to indicate any issues with carpal tunnel syndrome and/or cubital tunnel syndrome (PX 1).

Petitioner saw Dr. Santiago again on October 30, 2012, complaining that his grip strength was getting weaker. Petitioner reported undergoing no further treatment since February because his employer had no workers' compensation insurance and Petitioner had no personal insurance. Petitioner reported ongoing severe neck pain since his September 30, 2011 work accident with a great deal of pressure in his posterior neck region. He also reported more headaches with cramping in his hands. A history of carpal tunnel syndrome and cubital tunnel syndrome was noted. Petitioner felt his grip was getting weaker. He also had lower extremity complaints of numbness and tingling. The doctor noted that Petitioner's cervical range of motion was severely limited and slightly worse than at the last visit. The physical findings were unchanged from the first visit and again no recommendations were made regarding treatment of the upper extremity issues. (PX 4)

Petitioner saw Dr. Ochoa on November 1, 2012 but the records don't indicate any issues with carpal tunnel syndrome or cubital tunnel syndrome. (PX 1)

On March 11, 2013 Petitioner was examined by Dr. David Fletcher at the request of Attorney Todd Lichtenberger. Dr. Fletcher was asked to examine Petitioner in conjunction with a motor vehicle accident Petitioner had been involved in on September 30, 2011. Dr. Fletcher issued a written report in which he reviewed Petitioner's treatment which had been sporadic due to a lack of insurance coverage. As a result of the motor vehicle accident, Dr. Fletcher felt Petitioner had sustained a temporary aggravation of a pre-existing degenerative condition. He felt Petitioner was deconditioned and neurologically intact on exam. He had no atrophy and his hands were calloused. He doubted Petitioner would benefit from any further treatment but if he was treating him he'd recommend some additional physical therapy to strengthen him. Dr. Fletcher noted that Petitioner was a roofer by trade and currently worked for Moreman Home Improvement. Dr. Fletcher's March 11, 2013 report stated, "It is probable that the electrical study findings related to ulnar and median nerves was related to cumulative trauma from his trade as a roofer..." (PX11 - Ex. A).

On March 14, 2013 Petitioner filed an Application for Adjustment of Claim which alleged that he sustained accidental injuries arising out of and in the course of his employment for Respondent, Brian Moreman d/b/a Moreman's Home Improvement (hereinafter referred to as "Moreman"). The Application alleges a date of accident (manifestation) of March 11, 2013. In 13WC09600, the Application alleges that Petitioner sustained repetitive trauma injuries, specifically carpal tunnel syndrome and cubital tunnel syndrome, regarding his right hand, right arm, and left arm. (AX 3)

Dr. Santiago again examined Petitioner on May 13, 2013 regarding Petitioner's back pain. Petitioner had last been seen in October of 2012. Petitioner was noted to be on public aid and was complaining primarily about his leg and hip. He also reported neck pain and shooting pains into his arms with some pain and tingling around digits 4 and 5. His EMG findings of cubital tunnel syndrome were noted. No treatment recommendations were noted with regard to the EMG findings of cubital tunnel syndrome. There was no carpal tunnel syndrome diagnosis recorded. (PX 4)

Petitioner initiated care with Helping Hands Medical Clinic (hereafter referred to as Helping Hands) on May 14, 2013. Petitioner gave a history of being involved in a car accident that rendered him disabled. Among other issues Petitioner mentioned bulging discs in his neck and back, rheumatoid arthritis and worsening carpal tunnel in his wrists. No elbow complaints were noted. Petitioner was referred to an orthopedist for his carpal tunnel syndrome. (PX 5)

Petitioner was seen at Helping Hands on June 6, 2013 for blood work. (PX 5)

Petitioner returned to see Dr. Santiago on June 13, 2013. It was noted that Petitioner was scheduled for cubital/carpal tunnel releases the following week. (PX 4)

Petitioner was seen at Helping Hands on June 13, 2013. He reported a cramping sensation in the palm of his right hand and pain in his right elbow described as a "pulling sensation." (PX 5)

Petitioner had his initial orthopedic consultation with Dr. Plattner's office on June 21, 2013. Janis Ostiguy, NP, examined Petitioner at that time. Ms. Ostiguy noted right hand numbness and tingling with decreased grip strength. No mention of work duties or Petitioner's association of his complaints with his work duties as a roofer while working for Moreman was noted. Ms. Ostiguy was more concerned about Petitioner's other medical problems and referred Petitioner to the Carle Spine Center (PX6). The medical note indicates symptoms in the upper extremities but classified the carpal tunnel as "down low on the totem pole" and she recommended a consultation with a spinal surgeon. X-rays of Petitioner's elbows were taken. The left elbow x-ray showed bony fragments on the medial epicondyle presumably reflecting an old injury or possible chronic calcific tendinitis. A prominent insertional spur off the posterior olecranon was noted. The right elbow x-ray showed a similar prominent on the posterior olecranon. (PX 6)

Petitioner suffered a heart attack in July of 2013. (PX 6)

Petitioner presented again to Helping Hands on July 11, 2013, July 31, 2013, August 28, 2013, and October 23, 2013, but none of those appointments appear to address any issues involving the upper extremities (PX 5).

Petitioner continued to treat with Dr. Santiago and presented for appointments on July 12, 2013, September 13, 2013, October 11, 2013, and November 11, 2013. No diagnosis of carpal tunnel syndrome is noted during those visits. (PX 4)

Petitioner presented to Dr. Harms and Glenett Barrett, NP, at the Carle Spine Institute on September 16, 2013 (PX6). Petitioner reported arm pain, elbow pain, and locking of his hands. A diagnosis of carpal tunnel syndrome was noted. "He is not sure what really instigates the problems." Petitioner's treatment options were limited due to his prior heart attack. He was instructed to return in six weeks. (PX 6)

Petitioner was also seen at Helping Hands on October 23, 2013. He was requesting a hospital bed for his neck and back complaints. (PX 5)

Petitioner presented to Dr. Santiago on November 11, 2013. Petitioner reported that Dr. Johnson said his cubital tunnel syndrome was not related to his neck pain[1]. Some of those records reference symptoms in Petitioner's right elbow but it does not appear that treatment for those issues was being addressed by Dr. Santiago. The medical notes suggest that the upper extremity symptoms were being treated by Dr. Plattner of Carle Clinic. The records contain no mention of any association between Petitioner's upper extremity complaints and his former work duties for Respondent Moreman. No mention is made of carpal tunnel syndrome or left cubital tunnel syndrome. (PX 4)

Petitioner presented again to Dr. Plattner on November 11, 2013. Petitioner was reporting neck pain radiating to his shoulders and arms. Petitioner had been seen by Drs. Harms and Johnson. His degenerative disc disease in his spine was described as fairly advanced. The possibility of a double crush injury was noted. Petitioner was referred to Dr. Aronson for a repeat neurological study. (PX 6)

Petitioner was seen at Carle Rheumatology on December 4, 2013, per the referral of Dr. Victoria Johnson. Petitioner reported that all of his pain symptoms started in 2011 after a motor vehicle accident. He complained of neck and hip pain but denied any numbness and tingling. He did report an occasional "cramp" in his hand and that he would momentarily lose range of motion for up to a minute. Petitioner acknowledged having been diagnosed with rheumatoid arthritis but didn't recall any blood tests being done. He also reported that his pain medication had been cut off by Dr. Santiago after Petitioner reported that his pain pills had been stolen and he had a negative urine test. Dr. Ahmad (Spine Institute) had noted in November that Petitioner's symptoms did not match the MRI findings. Petitioner was noted to be on disability since the motor vehicle accident but had worked construction prior thereto. The doctor wanted to proceed with a work-up for rheumatoid arthritis as he felt, clinically, Petitioner showed more signs of osteoarthritis than rheumatoid arthritis. (PX 6)

Bilateral wrist x-rays taken on December 20. 2013 showed mild osteoarthritic changes at scattered joints. (PX 6)

Petitioner was also seen at Helping Hands on January 3, 2014 and January 20, 2014 regarding cold symptoms. (PX 5)

Petitioner continued to treat with Dr. Santiago and presented for appointments on January 22, 2014, February 19, 2014, March 17, 2014, and April 28, 2014. Some of those records reference right elbow complaints but it does not appear that treatment for those issues was being addressed by Dr. Santiago. The medical notes suggest that the upper extremity symptoms were being treated by Dr. Plattner of Carle Clinic. The records contain no mention of any association between Petitioner's upper extremity complaints and his work duties. (PX 4)

Petitioner was also seen at Helping Hands on February 17, 2014 regarding a sleep study that had been recommended at his January 20, 2014 appointment. Petitioner was still waiting for the study to be performed. He needed a Disability Parking Card completed. (PX 5)

[1] Dr. Johnson's records were not a part of the record.

Petitioner was also seen at Helping Hands on April 1, 2014 requesting medication for his neck and back pain. (PX 5)

Petitioner was also seen by Dr. Santiago on June 13, 2014, complaining of cramping in his palms. Petitioner reported that Dr. Plattner was going to do cubital tunnel / carpal tunnel releases (PX 4).

Petitioner presented to Dr. Aronson at Carle Neurology for the repeat neurological study on June 18, 2014. He reported a longstanding history of numbness and paresthesia in his hands predominately affecting his right hand. The doctor noted that activities and repetitive motions would aggravate Petitioner's hand. No definite weakness was noticed. Petitioner also reported some discomfort along his musculature due to chronic neck and back pain. Petitioner was noted to be a former roofer, having performed manual labor for a number of years. The EMG was performed and showed mild-to-moderate right carpal tunnel syndrome, minimal-to-mild left carpal tunnel syndrome and no sign of ulnar neuropathy. Petitioner was to follow up with Dr. Plattner. (PX 6)

On June 24, 2014, Petitioner followed up with Dr. Plattner. They reviewed the electrodiagnostic studies and the doctor discussed the nature of the problem with Petitioner. Noting he had tried conservative measures, Petitioner wished to proceed with surgery pending clearance by his primary doctor in light of Petitioner's heart condition. (PX 6)

Petitioner was cleared for surgery. (PX 6)

On July 17, 2014, Dr. Plattner performed right carpal tunnel release surgery. (PX 7)

Petitioner had two post-surgical follow up visits with Dr. Plattner on July 25, 2014 and August 1, 2014. Dr. Plattner noted that Petitioner was coming along well from the surgery. It was also noted that Petitioner had some pain and inflammation in his left hand that his doctor opined was related to his rheumatoid arthritis. (PX 6)

On October 19, 2015 Arbitrator Gallagher entered a decision in case #11 WC 040147 denying Petitioner's claim for compensation. (IWCC website)[2]

Petitioner filed a Motion for Penalties and Attorney's Fees in this matter on/about May 12, 2016. (PX 11)

Petitioner's case proceeded to arbitration on September 21, 2017. All issues were, essentially, in dispute. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he was hired to work for Respondent, Moreman's Home Improvement, by Brian Moreman and that he worked there for three months from July 2011 to October 2011. Petitioner testified that Mr. Moreman supervised him and Petitioner understood that Mr. Moreman could fire him. Petitioner also testified that there were other employees that worked at the same time that he did, and that Mr. Moreman advised them when and where they should report to work. Petitioner also testified that Mr. Moreman provided most of the tools and equipment but that Petitioner did bring some of his own tools to the job site including a hammer, a roofing bar, tape measure and cutting knives. Mr. Moreman provided ladders, compressor and guns, roofing guns, simplex nailing and all other tools needed to put in a roof, doors or windows. Petitioner performed roofing, siding, installation of doors and windows and general contracting for residential projects. Petitioner testified that he was paid by the hour and that Mr. Moreman kept track of the hours he worked.

[2] The decision as affirmed by the Commission in a decision dated 9.27.17. (IWCC website)

Petitioner explained the steps to putting on a roof as follows: putting out tarps, covering objects on the ground such as air conditioning units and bushes, putting up the ladders, using a hay fork or a shovel to pry the existing shingles up, taking off the black paper and the drip edge, replacing any bad wood, removing any hammered down nails, putting up new black paper and then installing the new shingles. Petitioner testified that the tools used are a hay fork or a roofing ripper known as a "shindigz" and allow you to use both hands to pry up nails. The tool is a flat bar at the bottom with a cut out for the nails and a 3 foot handle with a 4 inch piece of metal with grooves for the nails to slide in so they can be popped off. This tool weighs approximately 5 pounds.

Petitioner explained the process of stripping off a roof as placing the shovel or hay fork or roofing tool under the shingles and prying them up using a little bit of force and gripping the tool with both hands on the bar with a firm grip. Petitioner also testified that one task he performed was replacing 4 foot by 8 foot plywood sheets weighing 10 to 15 pounds on the roofs. Petitioner testified that depending on the pitch of the roof, his wrist position could be bent or straight. Petitioner also testified that he had to put felt down with a nail gun weighing between 3 to 5 pounds as well as put new shingles on with the nail gun. Petitioner testified that he used his right hand on the nail gun. Another task performed by Petitioner was carrying bundles of shingles weighing 10 to 20 pounds to the roof at an average rate of 10 to 20 bundles a day.

Petitioner testified that he is right handed and used the nail gun with his right hand.

Petitioner testified that during the approximately 7 hour work day he would be using his hand constantly gripping and grasping objects, carrying objects, or using force to pry up shingles and put down shingles. Other tasks include installing doors, windows and siding and using hammers, roofing bars or pry bar.

Petitioner testified after working for Mr. Moreman for about a month or a month and half, he noticed swelling in his right hand across the middle finger knuckle, the ring finger knuckle and pinky knuckle and his arm. Petitioner testified that he put ice on his hand but kept working and after a few weeks the swelling went down and then he began experiencing cramping and tingling. Petitioner testified that he then sought treatment.

Petitioner testified that he was in a car accident in late September 2011 and sought medical treatment with Dr. Ochoa and reported the problems he was having with his right hand and arms and was referred to Dr. Tazudeen.

Petitioner testified that he saw some improvement but that he still has swelling, cramping, tingling and lack of grip. Petitioner testified that he has some weather sensitivity in his hands and that he has been diagnosed with rheumatoid arthritis. Petitioner testified that he is not claiming that his rheumatoid arthritis is related to work.

Petitioner testified that he saw Dr. Fletcher for an Independent Medical Examination as part of the litigation involving his automobile accident. Petitioner testified that he is not currently working and he is receiving SSI benefits.

Petitioner testified that his right hand still swells and cramps. He notices a lack of grip and ongoing tingling.

On cross-examination, Petitioner testified that he underwent nerve conductions studies in November of 2011 which showed carpal tunnel syndrome. Petitioner did not notify his employer of his diagnosis. Petitioner testified that the carpal tunnel treatment that he had occurred after October 2011.

Petitioner testified that he was involved in a motor vehicle accident on September 30, 2011 and that as a result, he suffered injured and filed a claim against Moreman Home Improvement alleging that he was permanently and totally disabled. Petitioner has not worked since September 30, 2011. Petitioner testified that he filed for SSI benefits some time in 2013.

Petitioner testified that prior to July 2011 he worked at Hodges Roofing and McLanes. At McLanes, Petitioner worked as a selector at a distribution center picking out orders from various items and loading them on a cart and delivering to the door. Petitioner testified that he used his hands and arms and every part of his body for this job. At Hodge's Roofing, Petitioner performed the same roofing work that he was at Moreman.

Petitioner testified that he first experienced swelling symptoms in August of 2011 and that prior to that he had never had any swelling in his joints. Petitioner did not know when he was diagnosed with rheumatoid arthritis but testified that the symptoms from it are primarily swelling, achiness, stiffness and cramping and that the swelling is primarily in his hands and elbows.

Petitioner testified that his medical bills have been paid by Medicaid or public aid and that he has not received any bills indicating that he owes a balance.

On re-direct examination Petitioner indicated that he did not have problems with his hands while working at Hodges Roofing or McLanes. He was also asked what he thought caused the problem with his right hand and elbows and he replied that he "guessed" he worse them out.

The Arbitrator concludes:

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

Petitioner provided no evidence that on March 11, 2013 the date of the injury, Respondent Moreman was still operating as a business and therefore there is no basis for the Arbitrator to conclude that Respondent Moreman was operating under and subject to the Act.

Issue B: On March 11, 2013 was there an employer-employee relationship?

Petitioner did not present any credible evidence showing that there was an employer-employee relationship existing on the date of the alleged accident, March 11, 2013.

Issue C: Did an accident occur on March 11, 2013 that arose out of and in the course of Petitioner's employment with Respondent?

Issue D: What was the date of accident?

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

Issue O: Admissibility of Petitioner's Exhibit 8

The Arbitrator wishes to address these issues together as they are inter-related.

Petitioner failed to prove he sustained an accident on March 11, 2013 that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his right hand and bilateral arms/elbows was causally related to that alleged injury or his work duties for Respondent Moreman. This conclusion is based upon the following.

Petitioner had not worked for Respondent since being involved in motor vehicle accident which occurred on September 30, 2011. That was nearly 18 months prior to his claimed onset/manifestation date of March 11, 2013.

Petitioner testified that after the motor vehicle accident on September 30, 2011, he "started having everything go haywire" with the hands, neck, and back and that he never had any problems with anything before that accident. After the motor vehicle accident, Petitioner reported problems with both upper extremities and an EMG was done on November 11, 2011, which evidenced bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. Thus, Petitioner knew he had those conditions years before March 11, 2013. Even setting aside the fact that this testing came after a motor vehicle accident, Petitioner did not testify to any left hand or bilateral elbow problems he associated with his job duties for Respondent. While his job as a roofer may have involved use of his arms and hands, he did not provide any testimony to suggest that his job duties were problematic for his left hand/wrist or elbows/arms. It is also apparent that a subsequent EMG performed on June 18, 2014 showed right carpal tunnel syndrome and minimal to mild left carpal tunnel syndrome but no evidence of cubital tunnel syndrome. Thus, it appears that Petitioner's alleged elbow problems resolved. In summary, Petitioner has two initial problems with liability. First, his medical records and testimony suggest all of his alleged problems stem from a motor vehicle accident and not repetitive job duties. Second, he provided no testimony, nor do the records reflect any histories, suggestive of work-related elbow or left hand problems.

Focusing on Petitioner's right hand complaints, Petitioner testified that after working for Respondent Moreman about a month or a month and a half, he noticed swelling in his right hand across his middle finger knuckle, ring finger knuckle and pinky finger knuckle. Petitioner testified that he put ice on his hand and kept working and, after a few weeks, the swelling went down; however, he began experiencing cramping and tingling for which he sought medical treatment. Quite succinctly, such a history is nowhere to be found in Petitioner's medical records thereby undermining Petitioner's credibility from the very start. The records introduced into evidence go back to October of 2011. There is no history of swelling followed by cramping and tingling. There is no reference to any association between alleged complaints of numbness and tingling in Petitioner's hands and his work duties for Respondent Moreman. Petitioner saw Dr. Santiago at Christie Clinic on February 7, 2012 (approximately three months after he stopped working for Respondent due to injuries sustained in a motor vehicle accident). At that time he gave the doctor a history of having been involved in a motor vehicle accident on September 30, 2011 when he was un-restrained and riding in the back of a van. Petitioner had symptoms in his neck and shoulder along with numbness and tingling in his hands. The doctor's records are silent as to any association between duties as a roofer and Petitioner's hand complaints. The Arbitrator is aware that Dr. Aronson noted in his June 18, 2014 office note that "activities and repetitive motions" would aggravate Petitioner's right hand and that Petitioner was a former roofer, having performed manual labor for a number of years. However, he did not record any history from Petitioner indicating Petitioner felt his right hand symptoms stemmed from his brief tenure with Respondent Moreman. Dr. Aronson's comments were general in nature and certainly do not equate to a causation opinion. The same may be said of the comment contained in the independent medical examination report of Dr. David Fletcher dated March 11, 2013, the admissibility of which is an additional issue in the case.

Petitioner's entire case is built around Dr. Fletcher's IME report of March 11, 2013. Dr. Fletcher's report was marked as Petitioner's Exhibit 8. At trial, Petitioner sought to introduce the report which was prepared by

the doctor after examining Petitioner for a neck and back injury Petitioner allegedly suffered as a result of an automobile accident occurring on September 30, 2011. This automobile accident is not the subject of this litigation and the report was prepared by Dr. Fletcher for the case of *Jones v. Moreman, et al*, 11 WC 009600.

Petitioner alleges that this report is admissible as an exception to the hearsay rule as a statement against interest under IL.R.Evid. Rule 801 (d)(2)(c) which exempts from the hearsay exclusion, "a statement by a person authorized by the party to make a statement concerning the subject." While Dr. Fletcher was an expert witness in separate litigation, Petitioner offered no evidence to show that Respondent Moreman authorized Dr. Fletcher to provide opinions concerning the subject of this case, specifically Petitioner's carpal tunnel injury and its relationship to Petitioner's work duties for Respondent. Furthermore, Petitioner had not yet filed this litigation as of the date of Petitioner's examination with Dr. Fletcher so there is no possible way Respondent could have authorized Dr. Fletcher to make a statement concerning the injury at issue.

In *Greaney v. Industrial Commission* (Michel Masonry Co.), 358 Ill.App.3d 1002, (2005), the Court held that reports prepared by experts, specifically IME reports prepared by examining doctors, are not admissible under the hearsay exception for statements against interest. 358 Ill.App.3d at 1010-1011. The *Greaney* Court explained that the Illinois Supreme Court in *Taylor v. Kohli*, 162 Ill.2d 91, 96 held that as a matter of law an expert witness is not *per se* an agent of the party who hired him or her and therefore the expert's statements are not admissible against that party's interest. *Kraft General Foods v. Industrial Comm'n*, 287 Ill.App. 3d 526, 531-32 applied the holding in *Taylor* specifically to examining physicians in workers' compensation actions.

The Arbitrator does note, however, that Petitioner's attorney attached a copy of Dr. Fletcher's report to his Petition for Penalties and Attorney's Fees. Respondent Moreman did not object to the admissibility of the Penalties Petition (Exhibit 11). Thus, the Arbitrator has reviewed it, and even if the report was admissible as an exception to the hearsay rule, she does not find the statement of Dr. Fletcher as contained therein, sufficient to establish a manifestation date or causation for Petitioner's alleged upper extremity conditions. Dr. Fletcher's report contains one sentence related to Petitioner's upper extremity injuries. It reads as follows: "[I]t is probable that the electrical study findings related to ulnar and median nerves was related to cumulative trauma from his trade as a roofer as opposed to acute trauma from a motor vehicle accident." (PX 8, p. 4; PX 11) This reference in and of itself, does not provide sufficient basis to find that Petitioner's work for Respondent caused or aggravated his condition of carpal and/or cubital tunnel syndrome. A complete and thorough reading of Dr. Fletcher's report shows that he was not asked to provide an opinion on the carpal and cubital tunnel syndromes and, furthermore, he did not have any specific information regarding the type of work that Petitioner was engaged in with the Respondent, how long he had been engaged in that work or what his daily activities consisted of in his employment with Respondent Moreman. Dr. Fletcher incorrectly noted that Petitioner was working for Respondent Moreman and he never expressed an opinion, within a reasonable degree of medical certainty, that Petitioner's upper extremity conditions were caused or aggravated by Petitioner's work duties for Respondent between July and September of 2011. As such, Dr. Fletcher was not qualified to give an opinion on causal connection because an expert's opinion based on guess, speculation, or conjecture is inadmissible. *Modeski v. Nacistar International Trans. Corp., 302 Ill.App. 3d 879, 886 (1999).* Dr. Fletcher's comment appears to be an attempt to negate causation between the motor vehicle accident and Petitioner's alleged injuries from it more than an in-depth inquiry and analysis as to causation between Petitioner's alleged upper extremity conditions and Petitioner's job as a roofer. As such, even if admitted, the statement contained within the report, in and of itself, is insufficient to establish accident and causal connection in the instant case.

It should also be noted that Petitioner was seen by at least five (5) treating physicians, including Dr. Plattner, an orthopedic surgeon who performed the right carpal tunnel release. None of those doctors provided testimony or any other evidence regarding a causal relation to Petitioner's work activities.

Because there are no qualified medical opinions supporting causal connection, and causal connection cannot be proven through symptoms alone, Petitioner has failed to prove be a preponderance of credible evidence that his current condition of ill-being is causally related to his work duties for Respondent Moreman or that any alleged accident arose out of his employment with Respondent Moreman.

The Arbitrator also notes that Petitioner's medical records, as well as his testimony at trial, indicate Petitioner has had, and continues to have, symptoms from rheumatoid arthritis. Those symptoms include swelling, lack of grip, cramping, and tingling. Petitioner presented no medical evidence to establish that his current symptoms are related to his right carpal tunnel syndrome as opposed to the rheumatoid arthritis. Furthermore, his cubital tunnel syndrome has resolved.

The Arbitrator also wishes to address Petitioner's credibility which she found lacking. His testimony as to what he noticed about his hands while at work between July and September 30, 2011 was not believable because it was not corroborated by any of the medical evidence contained in the record. Petitioner denied any problems with his hands while working for Hodges Roofing and McLanes; yet, he seeks to have the Arbitrator believe that all of his right hand and bilateral elbow problems began during his brief tenure with Respondent Moreman. There is no objective evidence corroborating this and it is difficult to believe he was having gradual and repetitive trauma issues while working for Respondent Moreman when extensive treatiing medical records don't ever suggest that. Petitioner also testified that he has not attempted to return to work since the motor vehicle accident from which he claims he was permanently and totally disabled; yet, Dr. Fletcher's report noted callouses on his hands, suggesting activity.

In summary, Petitioner has not met his burden of showing by a preponderance of admissible evidence that his right carpal tunnel and bilateral cubital tunnel syndromes arose out of and in the course and scope of his employment with Respondent or that his current condition of ill-being in his right hand and elbows is causally related to the injury or his employment with Respondent. Petitioner's alleged manifestation date for his injury is March 11, 2013. Petitioner worked for Moreman for three months from July 2011 to September 30, 2011 with his last day of work with Moreman was September 30, 2011. Petitioner was diagnosed with bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome on November 14, 2011. Petitioner did not provide notice to Respondent of this diagnosis and did not make a claim or file an Application until March 22, 2013.

Issue O. Other-Admissibility of RX1

Respondent Moreman is seeking to introduce the deposition testimony of Dr. David Fletcher in the case of *Jones v. Moreman, et al*, 11 WC 009600. Respondent's attorney contended that if PX 8 was admitted, then RX 1 should be also. Petitioner's objection to this deposition is that it is hearsay and also irrelevant since was not taken in the instant case. Dr. Fletcher's deposition is an evidence deposition and, therefore, is admissible under ILCS S.Ct. Rule 212(b) which states that the "evidence deposition of a physician or surgeon may be introduced in evidence at trial on the motion of either party regardless of the availability of the deponent, without prejudice to the right of either party to subpoena or otherwise call the physician or surgeon for attendance at trial." The attorneys agreed to the stipulation that the deposition was an evidence deposition and could be used in court and the same counsel as herein were present and had the right and the opportunity to cross-examine the deponent. Pursuant to *Thompson v. City of Bushnell*, 348 Ill.App. 395, a deposition taken in former suits between the same parties, involving the same questions or subject matter are admissible when a question arises again for judicial determination and it is not necessary that the parties be identical, or that there be complete mutuality in respect to their relationship to each other, or to the subject matter if the party against

whom the deposition is offered had the opportunity of cross-examination of the witness and ability to test the truth of their testimony.

It is interesting that Petitioner insists that the comments of Dr. Fletcher as stated in a report prepared in another case are relevant to his case in chief herein but doesn't feel the deposition taken in that other case should be admitted because it is irrelevant. This argument seems somewhat disingenuous. Petitioner has submitted the information as relevant and opened the door to the relevance by including the report in his exhibits.

In looking at PX 8 and RX 1, Petitioner's Exhibit 8 contains one sentence related to the Petitioner's upper extremity injuries which reads as follows: "[I]t is probable that the electrical study findings related to ulnar and median nerves was related to cumulative trauma from his trade as a roofer as opposed to acute trauma from a motor vehicle accident." (PX 8, p. 4) Dr. Fletcher was later deposed (RX 1). When asked about this statement in his deposition, Dr. Fletcher testified as follows:

Q.: Doctor, as we sit here today do you have an opinion to a reasonable degree of medical certainty as to whether any cumulative trauma that Mr. Jones may have been suffering from was related to his employment with Moreman Home Improvement.

A: I don't have an opinion to any definitive medical certainty. (RX1, p. 14:9-15).

Dr. Fletcher's testimony does not support Petitioner's case and further bolsters the Arbitrator's decision on liability herein.

Issue G: What were Petitioner's earnings?

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

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

Issue M: Should penalties or fees be imposed upon Respondent Moreman?

Based upon the Arbitrator's liability determination, the foregoing issues are moot. Petitioner's claim for compensation is denied and no benefits are awarded.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Bryant,

Petitioner,

vs. NO: 10 WC 41809

State of Illinois/Tamms Correctional Center, 18IWCC0465

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 17, 2017 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.

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: JUL 25 2018
SJM/sj
o-7/12/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRYANT, CYNTHIA
Employee/Petitioner

Case# **10WC041809**

SOI/TAMMS CORRECTIONAL CENTER
Employer/Respondent

On 11/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.36% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4377 MICHAEL MILES
3200 FISHBACK RD
PO BOX 907
CARBONDALE, IL 62903

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

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

NOV 17 2017

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

STATE OF ILLINOIS)
) ss.
COUNTY OF WILLIAMSON)

18IWCC0465

☐ 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

CYNTHIA BRYANT
Employee/Petitioner

v.

STATE OF ILLINOIS/TAMMS CORRECTIONAL CENTER
Employer/Respondent

Case # 10 WC 41809

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

DISPUTED ISSUES

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

18IWCC0465

FINDINGS

On **September 22, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$57,190.50**; the average weekly wage was **$1,099.81**.

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

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

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that she sustained an accident which arose out of and in the course of her employment on September 22, 2010. All benefits are denied. The Arbitrator makes no findings as to the remaining issues.

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

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

Signature of Arbitrator

November 15, 2017
Date

ICArbDec p. 2

NOV 17 2017

18IWCC0465

STATE OF ILLINOIS)
) ss
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CYNTHIA BRYANT
Employee/Petitioner

v.

Case #: **10 WC 41809**

STATE OF ILLINOIS/TAMMS CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Testimony

On September 22, 2010, Petitioner was 49 years old, single, and had no dependent children. She testified she was employed by Respondent as a Correctional Officer at their Tamms facility and had been at that facility since 1998. Prior to that, she was at Shawnee Correctional Center in the capacity of Correctional Sergeant. She filed an Application for Adjustment of Claim, alleging that her job-related repetitive activities caused injuries to both of her hands and elbows, her cervical spine, and the body as a whole. Respondent disputed the case in its entirety.

Petitioner testified that in July 2010 she woke up with neck pain and her hands were numb, which was not normal for her, and she made a doctor's appointment. She went to the doctor and was referred to a neuro-spine specialist. She underwent a nerve test and MRI's and the results were sent to Dr. Hahn, who advised her she had carpal tunnel in both hands and a degenerative disc in her neck. She testified she turned in light duty papers from Dr. Hahn to Respondent on September 22, 2010, and was escorted out the door a few hours later. When asked what her personal impression was of what was going on with her hands and neck, she testified, "I actually thought I just had slept the wrong way. Sometimes we sleep on the pillow the wrong way, and you might have a little crick in your neck. But the numbness in my hands, I didn't know what was going on with that, so I feel it was abnormal so I just made a doctor appointment because I needed to see what was going on."

Petitioner then read into evidence a narrative of her job duties, which she solely prepared and provided to Respondent's Section 12 examiner, Dr. Sudekum. The narratives were broken into two different positions—Pod Control Officer/Control Room Officer and Floor/Wing Officer. She began with Control room officer; testifying this was an assignment lasting only half

a day. As a control room officer she stated her job duties were to push down and hold buttons which opened various doors on the floor. She stated she would hold down the buttons with "pressure" although there was no testimony offered as to the amount of pressure required. At 7:15 a.m. according to Petitioner's testimony, she would have to push the button to open doors approximately 54 times. This was for the wing officers to count inmates, check showers; yards on each wing and sign wing books. At 7:45 a.m. she would be required to push the button 90 times for what she termed as a 30 minute wing check, run inmates through the yard and shower. At 8:15 a.m. she was required to push the buttons 168 times, opening and closing doors on each wing 28 times multiplied by six wings. She indicated that at 8:45 a.m. she pushed the button 204 times; at 9:15 a.m. it was 180 times; at 9:45 a.m. it was 234 times; at 11:15 a.m. it was 180 times; and at 11:30 a.m. she pushed the button 24 times. Petitioner testified she had to push buttons as a Pod Control Officer 1,548 times per day or 7,740 times a week. PX10, RX3.

Petitioner then turned to the duties of a Floor Wing Officer and again read into evidence that portion of her narrative. She testified that at 7:45 a.m. the floor wing officer is required to turn to unlock and lock the lower and upper storage closet, with there being two storage closets on each wing and six wings to each pod, making 24 times a round. Additionally, according to Petitioner, concurrently the floor wing officers were required to run showers. She testified she would have to use a large heavy metal key approximately 240 times. Her actual testimony was:

> *"We generally run five to seven showers on each wing before lunch because there are only—they are only to receive 20 minute showers. The approximate time I had to use a large heavy metal key is 36 times, the regular key is 24, running six inmates to the shower and back to his cell per wing is 60 times and for all six wings, its 360 times."*

Ms. Bryant also testified that she had to open and close chuckholes on cells and shower doors 3,534 times per week. PX10, RX3.

Petitioner testified that Dr. Hahn was her primary care physician and that he referred her to Diversified Rehab for physical therapy, which did not help her. Dr. Hahn then referred her to Dr. Karshner, who performed injections and additional physical therapy. Dr. Karshner referred her to Dr. Stahle, with Kirkwood Diagnostic and Orthopedic Associates. Dr. Stahle referred her to Dr. Lehman in March 2013, who subsequently diagnosed her with bilateral carpal tunnel syndrome. Petitioner testified that Dr. Lehman performed a surgical release on the right side on March 13, 2013. She did well after surgery, but the numbness returned in her hand. Dr. Lehman performed surgery on the left side on August 28, 2013. Petitioner testified that during the years of conservative treatment, prior to surgery, she was not working.

Petitioner testified that after her carpal tunnel releases she continued to have trouble with her neck. Dr. Lehman referred her to Dr. Forget, who diagnosed cervical radiculopathy. On April 4, 2014, Dr. Forget performed a posterior cervical facetectomy and microforaminotomy at C4-5. Petitioner testified she was satisfied with the results. After the surgery she returned to work for Respondent at the Vienna Correctional Center. She subsequently underwent right elbow surgery in June 2014, by Dr. Hagan, and returned to work on July 29, 2014. She worked at the Vienna facility until she retired in September 2016.

Petitioner testified she currently has continued numbness and tingling in her right elbow on the ulnar nerve. She is not having any problems with either the right or left wrist. She is also

not having any problems with her neck and has no more pain. She testified she is happy with her the results of her surgical procedures.

On cross-examination, Petitioner testified that she first started having problems with her elbow after her carpal tunnel surgeries in 2013, which she acknowledged was three years after her alleged date of accident of September 22, 2010. She acknowledged she never went back to work at Tamms, and did not work from September 2010 until she returned to work at the Vienna facility in 2014.

Petitioner was questioned regarding the job duties narrative she wrote (PX10, RX3) and the duties described therein. She testified she wrote the narrative by herself shortly after being taken off work. On re-direct, however, she agreed that she wrote it prior to her appointment with Dr. Sudekum on April 21, 2014, which was three and a half years after she left Tamms. With regard to the Control Room Officer job, she testified the job duties generally consisted of four hours, and was usually the first half of her day, with the other half as a Floor Wing Officer.

Petitioner admitted that the pods at Tamms had varying numbers of inmates within them, and had even been down to one inmate on a pod. When questioned about her numbers not being accurate on the narrative, she testified, "That's the reason I said approximately." It was pointed out by Respondent's counsel, however, that the narrative does not say "approximately". Petitioner conceded that although there are ten cell doors on each wing, she would only "sometimes" have to actually open all ten cell doors on each wing. She further conceded that opening the doors consisted of pushing the button that slid the door open, and that she did not physically open the door. She would receive word from the floor officer to open a door, at which time she would push the button to do so. She further conceded that Tamms was a "supermax" facility and the inmates were locked down 24 hours a day. They could, however, earn one hour a day to be in the yard. She estimated that ninety percent of the time only three to four inmates per wing were allowed in the yard. Overall, Petitioner testified that the daily activities of the Control Room Officer varied and depended upon the occupancy of the wing.

When questioned, Petitioner testified that the number of showers each inmate received varied, stating, "That also depends on what level they were at too. A lot of inmates got showers every day, okay. Some of them didn't." When questioned about why Petitioner had different numbers for essentially each paragraph and time, her response was; "sometimes when you do—we did 30-minute wing checks, right? Okay. The inmates get only a 20 minute shower. An inmate get yard for one hour. That's how the difference come in to play there. If you only moving a yard every hour, then that's—you have to take that out. But if you're moving yard, showers, also, then the number is going to go up." She admitted that the numbers would be contingent upon the occupancy of the wing, which varied. Additionally, she testified that working as a Control Room Officer also varied on how many days a week she was assigned to that position.

Petitioner conceded that at no point while she was actually doing her job did she notice numbness and tingling in her hands. With regard to her neck, she testified she started noticing problems about a month prior, when she was lifting the food carts to feed the inmates.

Respondent's representative, Jason Hall, was called by Petitioner to testify. Mr. Hall testified his current position was southern region Coordinator for Performance-Based Standards with the Department of Corrections. In 2010 he was working at Tamms Correctional Center as an Administrative Assistant II. He assisted the Warden and reported directly to do the Warden. He testified he worked as a Correctional Officer at Tamms from when it opened in 1997 until he left in 2001. He returned in 2004, but as an Administrative Assistant II rather than an officer.

Mr. Hall testified that he agreed with Petitioner's description of the duties required of a correctional officer at Tamms; however, he questioned her numbers. He testified:

> *"One thing I would question is the numbers are----there's a lot of assumptions built into that. That's assuming that an officer, whether it's Miss Bryant or any officer, is assigned to that position, whether it be for full day of work or a half day. And that's not taking into consideration of any other breaks, any other job duties outside of a pod or a housing unit or a wing officer. That's assuming that the wings are completely full for 10 offenders, 60 offenders in each pod. That's assuming that none of the offenders were unescorted. Some of the offenders that we had there, they achieved behavior level status to where they could go to yard, they could go to shower unescorted, which would not require an officer to go to the wing to open certain doors. That's assuming that everybody went to yard or went to shower every day, and a lot of those did not.....so there are assumptions built into that."*

Mr. Hall further testified that Tamms never reached full capacity from the time the first inmates arrived in 1998. As to whether the pods were ever at full capacity, he testified, "It was very, very minimal if, in fact, they were."

Mr. Hall agreed with Petitioner's estimation of the weight of the food trays and other things that were passed through the chuckholes. He testified that some of the chuckhole doors operated similar to an oven door, without the spring, and that some of them did stick. Others would fall open immediately.

On cross-examination, Mr. Hall was asked about Respondent's Exhibit 1, titled "Demands of the Job". He testified there was nothing on that list of duties that would require being done more than two hours a day. With regard to the narrative of job duties that Petitioner wrote for the Floor Wing Officer (PX10, RX3), Mr. Hall testified that the assumptions she built into her narrative would not be correct. He noted, "It would have to be a worst case scenario of just absolute minimum staffing, full capacity, and everybody is receiving their benefits of yard, shower, whatever that may be during the day." With regard to Petitioner's assertion in the document that as a Floor Wing Officer she had to open and close chuckholes on cells and shower doors approximately 717 times per day, Mr. Hall testified that with the circumstances under which the facility was operating, "that would not have been possible". Further, he testified that whatever the number was, it would be split between the number of officers assigned to the unit.

With regard to Petitioner's narrative of job duties for the Control Room Officer (PX10, RX3), and her assertion that she had to push and hold buttons down with pressure approximately 1,548 times per day, Mr. Hall testified as follows:

> *"Again, that is with the assumption that full capacity, full movement, and the visits to the housing unit that were indicated, whether it be medical staff, the doctor, out*

of cell time for mental health, anything, that's assuming, again, the most movement, worse case scenario."

Mr. Hall further testified that in his four years as a correctional officer at Tamms, the "worst case scenario" described above never occurred.

On re-direct, Mr. Hall testified that when Tamms initially opened there were three to four officers on the floor at a time. Toward the end of the Tamms tenure, there were two officers on the floor at a time.

Petitioner was recalled as a witness and testified that in the last couple of years that she was at Tamms, there were only two officers on the floor and one of them was a tact officer. The tact officer's responsibility was to make all "out of pod" moves. As such, many times there was only one officer on the floor.

Medical

On July 26, 2010, Petitioner presented to Dr. Mark Hahn of Plaza Primary Care. She reported constant and moderately severe numbness and tingling in the second and third digits of her left hand, with an acute onset a month prior. She also reported pain in her neck which was sharp and worse with lifting. She had tried over the counter medications without relief. She reported she worked as a corrections officer, but no additional information was noted with regard to same. On examination, Tinel's and Phalen's were positive on the right, there was tenderness to palpation over the right paracervical spinal muscles, and strength and reflexes were intact. Dr. Hahn ordered cervical x-rays and an EMG/NCS and prescribed Naprosyn. PX1.

On August 6, 2010, Petitioner underwent an EMG/NCS. She reported a four-week history of paresthesias in the fingertips and neck pain which occasionally would shoot down her neck. She reported the left side was more symptomatic. The tests revealed (1) a mildly compressive median neuropathy at both wrists; and (2) lower cervical nerve root compression causing radiculopathy. PX1.

Petitioner underwent a cervical MRI on September 8, 2010, which revealed mild multilevel cervical degenerative spondylosis, most significant at C4-5. PX1.

On September 16, 2010, Petitioner presented to Brain and NeuroSpine Clinic of Missouri, upon referral by Dr. Hahn, and was evaluated by Physician's Assistant Ashley VanZant. She complained of neck pain and bilateral hand numbness of about six to eight months. It was noted, "She states she woke up with these symptoms one morning, she denies injury." The pain did not radiate into her arms, but she did have constant bilateral hand numbness and she felt weak in her arms. She had tried an anti-inflammatory, which upset her stomach. She wore a left wrist splint at night. On exam, cervical range of motion was full in all directions without tenderness, Spurling's sign was negative bilaterally, and there was no tenderness or spasm. There was a trigger point in the right trapezius. Exam of the hands showed negative Tinel's and positive Phalen's bilaterally. PA VanZant administered a right trapezius trigger point injection, added a right wrist splint, prescribed physical therapy to include cervical traction, and prescribed Mobic. She was placed on work restrictions of no lifting more than 20

pounds and was to return in six weeks. PX2. The Arbitrator notes this was the only record from this provider.

On September 23, 2010, Petitioner presented to Diversified Rehab, upon referral by PA VanZant. She reported she worked as a corrections officer and was responsible for carrying food trays, moving inmates, etc. She stated her pain increased when carrying a heavy load. She further reported she had pain at home with lifting pots and pans. She had weakness in her hands and tingling in her fingers. She noted the most difficult and painful thing was carrying loaded food trays. She advised the trigger point injection received did not help with her neck pain. Petitioner attended physical therapy through October 8, 2010, without much relief. PX3.

Petitioner returned to Dr. Hahn on September 29, 2010. He noted that Petitioner had an onset of neck pain a year prior and that the pain was severe and daily, and radiated to the scalp. She reported that her employer could not provide light duty and she therefore needed paperwork completed for short-term disability. Dr. Hahn also noted Petitioner had onset of carpal tunnel syndrome six months prior and that the symptoms were moderate and intermittent. She reported the symptoms were aggravated by repetitive work and hand-intensive activity. Dr. Hahn noted, "The risk factors include female and high risk employment". He did not elaborate further. Assessment was degenerative cervical disc and carpal tunnel syndrome. PX3. Dr. Hahn completed FMLA and short-term disability paperwork at Petitioner's request. PX11.

Petitioner completed an Employee's Notice of Injury on September 29, 2010, and indicated her injury was neck pain and numbness in both hands. There is nothing noted with regard to her elbows. She stated the injury occurred from lifting heavy food carts and pushing buttons in the control room. She reported that the food carts weighed about 10 pounds when empty and 15 to 25 pounds when loaded and that carrying them up and down stairs on each wing caused a strain on her neck, as did pushing buttons in the control room. An Employer's First Report of Injury was completed that day as well, which restated Petitioner's report. On October 1, 2010, a Supervisor's Report of Injury was completed, noting "unknown" for activity, date of accident, and description of accident. A Demands of the Job form was completed the same day. Within the document there were 31 tasks listed with a corresponding grade listing the amount of hours per day each task was conducted. For Petitioner, there was no category which listed two to four hours or more. RX1.

On October 21, 2010, Dr. Hahn authored a letter which indicated Petitioner was being treated for cervical degenerative disc disease and bilateral carpal tunnel syndrome. He stated, "It is of my professional opinion that some of her carpal tunnel symptoms could be the result of years of repetitive motion of her arms and hands such as pushing buttons and the like." PX3.

On November 15, 2010, Petitioner returned to Dr. Hahn and reported persistent pain in her neck which radiated to both arms which was aggravated by activity. It was noted she had not been going to physical therapy, as it had not been approved. Exam and assessment were unchanged. Petitioner was to remain off work and attempt to get into therapy. She followed up on December 13, 2010, and reported no change. Exam and assessment were unchanged. PX1.

On December 20, 2010, a Job Analysis was conducted by CorVel for Petitioner's position. It was noted that on the day of the analysis the headcount was 207 and the average number of inmates was 40 to 42 per pod. It was further noted that the prisoners remained in their cells approximately 20 to 23 hours per day. Major Homer Markel advised that Petitioner had applied to an internal posting for a 90-day voluntary assignment to the Employee Commissary Area, a position she held from June 28, 2010, through September 17, 2010. Petitioner supervised inmates as they loaded and unloaded carts with supplies and sat with inmates in training, to supervise them stocking the area with supplies. Prior to that position, Petitioner was the Union President for two years, until July 2010. She brought visitors to inmates, using one single key, she performed union business, pushed a food cart perhaps twice a month, and handled a food tray two to three times a month when assigned to a pod. The Job Analysis went into detail with regard to the duties and daily schedules for a corrections officer. RX4.

On January 10, 2011, Petitioner returned to Dr. Hahn, with continued complaints of neck pain that radiated to the back and shoulder and carpal tunnel syndrome. Exam was unchanged. She returned on February 9 with the same complaints. With regard to her wrists, it was noted that "symptoms are aggravated by driving and forceful work". The Arbitrator notes, however, that Petitioner had not worked for Respondent since September 22, 2010. Dr. Hahn noted he had spoken with Petitioner's attorney regarding the status of her case and advised he would write a letter "regarding possible causative/contributing factors to her development of cervical disc disease as well as CTS and will go from there". Petitioner followed up on June 21, 2011, and reported that the severity of her neck problem was incapacitating. Her carpal tunnel symptoms had not changed and were described as moderate. PX1.

Petitioner returned to Dr. Hahn on July 22, 2011, and reported her symptoms had not changed with regard to both her neck and her wrists. Exam and assessment were unchanged. The same was true when she returned on August 22, September 23, November 21, and December 22, 2011. It was noted on several occasions that her carpal tunnel symptoms were "aggravated by forceful work, repetitive work/hand intensive activity and sustained hand positions". It was also noted that her cervical symptoms were aggravated by twisting and working. The Arbitrator again notes that Petitioner had not worked for Respondent since September 22, 2010, a fact which Dr. Hahn did not appear to be aware of. PX1.

Petitioner continued treating with Dr. Hahn on January 24, 2012, February 28, March 12, and April 12, 2012. Her complaints were unchanged, as were her exams and assessment. PX1.

On April 8, 2012, Dr. Hahn testified by way of deposition. He is a Doctor of Osteopathy and a family practice physician. He testified he was Petitioner's primary care provider and had been so since 2007. He testified consistent with his treating records. He acknowledged he was not very familiar with Petitioner's daily duties as a corrections officer, but was aware that she took meals to prisoners, transferred prisoners, dealt with documentation, and the like. She had also mentioned working in the control room, but he was not aware of the specifics involved. He testified that Petitioner related activities such as lifting, carrying trays, typing, and bending aggravated her symptoms in her hands and neck. He testified she had been treated conservatively with anti-inflammatories, muscle relaxers, wrist splints, topical heat, rest, and light duty work. He had recommended physical therapy, but it had not been approved. Dr. Hahn

testified that Petitioner's repetitive work and "items that she was most likely doing at her job" could be aggravating to the point that would require treatment. PX8.

On cross-examination, Dr. Hahn testified that to the best of his knowledge, Petitioner did not have any complaints to her upper extremities or neck prior to July 26, 2010. He conceded that he had never reviewed any job description for a correctional officer position at Tamms, had never reviewed a job site analysis or video depicting the duties, had never visited Tamms, and was not aware of how many job assignments there were for a correctional officer at Tamms. He was not aware of how long Petitioner had worked at Tamms. Dr. Hahn acknowledged that, in forming an opinion on causation, it would be helpful to know Petitoner's job duties, including the frequency, duration, and intensity with which she did those job duties. He conceded he did not know what shift or days Petitioner worked, or whether the officers rotated positions. PX8.

Dr. Hahn testified that Petitioner mentioned she took meals to inmates, which involved pushing the cart that contained the trays, removing the trays, passing them to the inmates, and then collecting them all after the meals. He did not know the weight of the trays or the cart. He acknowledged it would be of benefit to know those things in determining whether it was a causative factor in her neck or upper extremity complaints, but testified that it would most likely be repetitive and that the frequency, not necessarily the weight, would be a factor. He did not, however, know the frequency with which Petitioner was performing that job duty, and conceded that would possibly be important in knowing whether it was a causative factor. PX8.

Dr. Hahn further acknowledged that he had no details with regard to the job duties of transferring inmates or paperwork. He did not know the type of doors or keys used at Tamms, how inmates were moved, or how many times a day Petitioner would turn a key. He conceded that information would be important in determining whether the duty was repetitive. He did not know how many times a day Petitioner passed the food trays and testified that he relied upon Petitioner's assertion that it was repetitive. With regard to working in the control room, Dr. Hahn testified that pushing buttons and turning knobs and switches would be considered repetitive and a risk for carpal tunnel syndrome. However, he did not know how many times Petitioner might perform those tasks and conceded it would be important in knowing whether her duties were repetitive. PX8.

On May 14, 2012, Petitioner returned to Dr. Hahn, with the same complaints with respect to her hands and neck. Exam and assessment were unchanged. The same was true on June 15, July 16, August 15, September 14, October 18, and November 29, 2012. PX1.

On August 20, 2012, Petitioner presented to Dr. Matthew Karshner at Southeast Physical Medicine and Rehab, upon referral by Dr. Hahn. She reported neck pain for two years which was moderate and constant, and aggravated by lifting and turning her head. There was no mention of her carpal tunnel symptoms, or her work duties as a causative factor of either condition. Assessment was degenerative disc and joint disease, cervical stenosis, and myofascial muscle pain. Dr. Karshner administered trigger point injections in the right trapezius and right cervical arcas. Petitioner returned to Dr. Karshner on September 4, 2012, and complained of right shoulder pain radiating to the right arm. She underwent trigger point injections in the right trapezius and right cervical areas and was referred to physical therapy. PX4.

On September 21, 2012, Petitioner returned to Dr. Karshner and continued to complain of right shoulder pain. Records from HealthPoint Rehab indicated she had been seen 17 times for therapy at that point. Dr. Karshner administered trigger point injections in the right trapezius and right cervical areas and instructed her to continue with therapy. She returned on October 10, at which time Dr. Karshner recommended an EMG/NCS. She continued with therapy at HealthPoint and reported injections gave relief for about two weeks. On October 22 she returned to Dr. Karshner and reported continued right shoulder pain. An EMG/NCS was conducted, which showed an ulnar conduction defect at the right elbow, consistent with cubital tunnel syndrome. An MRI of the right elbow and forearm was ordered. PX4.

On November 2, 2012, Petitioner underwent an MRI of the right upper extremity, which revealed: (1) ulnar neuropathy/neuritis; (2) distal triceps and biceps tendinosis without a tear; (3) scarring of the subcutaneous tissues overlying the olecranon process; (4) lateral epicondylitis with tendinosis and low grade partial tear involving the common extensor tendon with no full-thickness tear or tendon retraction; (5) scarring due to chronic sprain of the radial collateral ligament without a tear; and (6) mild degenerative changes of the elbow. PX4, RX9.

Petitioner returned to Dr. Karshner on November 5, 2012, with complaints of right elbow pain, onset one month prior. Assessment was lesion of ulnar nerve, and Dr. Karshner administered a trigger point injection in the right cervical area. Petitioner continued to receive physical therapy at HealthPoint. She returned to Dr. Karshner on December 12 and received trigger point injections in the right trapezius and right cervical areas. PX4.

On January 2, 2013, Petitioner followed up with Dr. Karshner, who assessed lateral epicondylitis, tendinopathy of the elbow, and cubital tunnel syndrome on the right side. He referred Petitioner to Dr. Steven Stahle, who she saw on January 16, 2013. Dr. Stahle recommended a cervical MRI and opined Petitioner would need surgery. The cervical MRI was completed that day, which revealed (1) C4-5 and C5-6 bulges and facet arthropathy with stenosis; and (2) C3-4 and C6-7 bulges with dural displacement but no stenosis. The Arbitrator notes there are no additional records from Dr. Stahle. Petitioner returned to Dr. Karshner on February 4, 2013, and assessment was lateral epicondylitis. She underwent trigger point injections in the right trapezius and right cervical areas. PX4.

Dr. Karshner's records show that Petitioner called the office on February 5, 2013, and stated she needed a letter with her restrictions, as her employer wanted her to return to work. On February 8 she called again and stated she needed additional restrictions. She asked if she could do steps and standing and for how long, the time frame for repetition with her hands, and whether she could use her weapon with recoil to her shoulder. Dr. Karshner noted her restrictions would be no weapon use, no limit with steps and standing, no limit on right hand use, but a 10 pound limit. Petitioner returned to Dr. Karshner on February 25 and underwent additional trigger point injections in the same areas. PX4.

On March 7, 2013, Petitioner presented to Dr. Richard Lehman, upon referral by Dr. Karshner. She complained of right elbow pain and tingling and numbness in her fourth and fifth fingers. Dr. Lehman noted, "She had a nerve conduction study in January of 2010 which showed

a compressive median neuropathy at both wrists and a right ulnar nerve motor action potential abnormality suggestive of right lower cervical radiculopathy." It is unclear whether the reference to 2010 was an error, but the Arbitrator notes that this pre-dated Petitoner's alleged date of accident of September 22, 2010. Dr. Lehman recommended surgery for right ulnar nerve transposition and carpal tunnel release, which was performed on March 13, 2013. PX5.

Petitioner returned to Dr. Karshner on March 18, 2013, with complaints of pain in the right elbow, right shoulder, and neck. She underwent a trigger point injection in the right cervical area. PX4. The Arbitrator notes this is the final record from Dr. Karshner.

Petitioner followed up with Dr. Lehman on March 19, March 26, May 2, June 5, and August 8, 2013. On August 28 she underwent a left carpal tunnel release by Dr. Lehman. She followed up on September 9 and October 24, at which time he noted she appeared to have an inflammatory component in her cervical spine and that she had a herniated disc. He recommended an epidural injection and mentioned the possibility of referral to a neurosurgeon. Petitioner returned on December 3 and 17, 2013. Her last appointment with Dr. Lehman was January 21, 2014, at which time she complained of continued issues with her left hand but primarily had problems with her cervical spine. Dr. Lehman noted she had undergone a number of epidural injections, which did not resolve her pain, and he recommended she obtain a second opinion from a neurosurgeon with respect to her cervical spine. PX5. The Arbitrator notes this is the final record from Dr. Lehman.

On January 28, 2014, Petitioner underwent an MRI of the left upper extremity, as ordered by Dr. Lehman for pain in the center of the palm following carpal tunnel surgery. It revealed (1) no acute fracture or stress fracture; (2) first metacarpal phalangeal joint effusion with osteoarthrosis; (3) scar tissue to the carpal tunnel from question attempted release and possibly some mild residual median neuritis. RX9.

On February 17, 2014, Petitioner presented to Dr. Robert Hagan at STL Plastic and Hand Surgery, upon referral by Dr. Lehman. Dr. Hagan noted her history of right ulnar nerve and carpal tunnel surgery, with her right hand symptoms having resolved. He further noted persistent left ulnar symptoms consistent with not recurrent carpal tunnel, but primary ulnar nerve. Her examination was positive for cubital tunnel and compression at Guyon's canal, and she had a very focal tender spot in the proximal hyper thenar region. Dr. Hagan noted Petitioner was scheduled for a cervical spine evaluation with Dr. Forget the following week and that if he found no cervical surgical pathology, Dr. Hagan would recommend cubital tunnel release and Guyon's canal release. PX7.

On February 19, 2014, Petitioner presented to Dr. Thomas Forget of Neurosurgical Specialists of West County, upon referral by Dr. Lehman. She complained of pain, numbness, and tingling in her left arm. He noted a history of neck pain "for 3 months" and further noted her prior right ulnar and carpal tunnel releases. Dr. Forget recommended a cervical MRI, which was conducted on March 4, 2014. It revealed prominent degenerative changes, most significant at C4-5, with effacement and significant foraminal stenosis, especially to the right. On March 11, 2014, Dr. Forget authored a letter to Dr. Hagan, advising that the MRI showed a bone spur on the right at C4-5, which he believed was causing Petitioner's right arm symptoms. He believed that

her left arm symptoms were caused by her left ulnar neuropathy. He advised he would be performing a right C4-5 posterior cervical foraminotomy and that Petitioner should follow up with Dr. Hagan regarding ulnar nerve decompression. PX6, RX8.

On March 31, 2014, Petitioner underwent cervical surgery by Dr. Forget, which consisted of a right C4-5 posterior facetectomy and microforaminotomy. She followed up with Dr. Forget on April 15, 2014, and reported that her preoperative symptoms had resolved. She had some tightness when turning her head, but heat and muscle relaxants helped. Dr. Forget released Petitioner at that time. PX6, RX8.

On April 21, 2014, Petitioner was evaluated by Dr. Anthony Sudekum of Missouri Hand Center, Respondent's Section 12 examiner. Dr. Sudekum authored a 62 page report in which he recorded he had been asked to evaluate Petitioner regarding her neck, shoulder and bilateral upper extremity conditions and symptoms. He noted that in preparing the report he had reviewed extensive records, interviewed Petitioner and performed diagnostic testing. Dr. Sudekum opined that Petitioner did not sustain any injury to either upper extremity on September 22, 201, or prior to that time as a result of a work related injury or incident at Tamms Correctional Center. He noted her left ulnar neuropathy symptoms were not present in 2010 and the nerve conduction studies performed by Dr. Koonce in August 2010 revealed no electrodiagnostic evidence of ulnar neuropathy at that time. Dr. Sudekum opined:

> *"It is my opinion with a reasonable degree of medical certainty that Ms. Bryant's primary left palmar pain, paresthesias and left hand symptoms are due to post operative compression and/or irritation of the ulnar and median nerves secondary to scar tissue which formed in the palm around those nerves after her carpal tunnel surgery in August 2013."*

He further stated:

> *"I did not identify any significant or sustained repetitive impact to the hand, repeatedly heavy gripping, grasping or pounding with the hand, use of vibratory tools or abnormal, sustained wrist or elbow postures involved in the Correctional Officers job at Tamms Correctional Center. The routine manual tasks performed by Correctional Officers at Tamms Correctional Center, are relatively benign, non traumatic activities that would not normally cause or aggravate carpal tunnel syndrome, cubital tunnel syndrome, medial epicondylitis and/or other common upper extremity "repetitive/cumulative trauma injuries."* RX2.

Dr. Sudekum noted that Petitioner had significant non-work related factors which predisposed her to neck and upper extremity pain, upper extremity peripheral neuropathy symptoms/paresthesias, carpal tunnel syndrome and or/cubital tunnel syndrome. Those factors included her gender, her age over 52 years, a long smoking history, hypertension/fluid retention requiring a diuretic, chronic relatively severe multilevel degenerative arthritis of the cervical spine, cervical disc disease and cervical radiculopathy requiring surgical treatment and possible motorcycling. He stated:

> *"It is my opinion, with a reasonable degree of medical certainty that Ms. Bryant's job as a correctional officer at the Tamms Correctional Center, her previous employment the Centralia Correctional Center and or a reported work-related injury of September 22, 2010, did not cause or aggravate carpal tunnel syndrome, cubital tunnel syndrome,*

her current left ulnar neuropathy at her palm/wrist and/or elbow, osteoarthritis of the cervical spine, multilevel degenerative cervical disc disease and or cervical radiculopathy." RX2.

On June 5, 2014, Petitioner underwent surgery by Dr. Hagan which consisted of (1) left decompression neurolysis of the ulnar nerve at the wrist/Guyon's canal; (2) left decompression neurolysis of the ulnar nerve at the distal arm, cubital tunnel, and proximal forearm; and (3) left transposition of the ulnar nerve and flexor forearm muscle release. PX7. The Arbitrator notes this is the final record from Dr. Hagan and the final treatment record.

Dr. Sudekum testified by way of deposition on April 9, 2015. He is double board certified in the areas of plastic and reconstructive surgery. He has an additional board certification in surgery of the upper extremity and a certificate of added qualification for surgery of the hand. His practice involves the evaluation and treatment of any and all conditions affecting the upper extremity, which can include conditions involving the neck and shoulder as they may relate to symptomatology in the upper extremity. RX5.

Dr. Sudekum testified consistent with his report of April 21, 2014. He noted that Petitioner had provided him with a job description she had written herself and that it was written in such a way as to describe what individuals in that position "might do". Dr. Sudekum also noted he had reviewed the Job Site Analysis performed by CorVel which, among other things, indicated that the Tamms facility was at only 42% capacity. He testified this was relevant because the number of key turns, button pushes, and movement of inmates would be much lower—less than half—than the number indicated by Petitioner. In addition, Dr. Sudekum testified that Petitioner's calculation of the number of keys turned and buttons pushed was significantly different from the numbers described in the job site analysis or Major Markel's repetitive movement report. Her numbers were double, and in some cases more than that. RX5.

Dr. Sudekum testified that Petitioner had several comorbid factors that predisposed her to the development of carpal or cubital tunnel syndrome, including her age, her gender, her hypertension requiring a diuretic, her obesity, her cervical degenerative disease, and her 30-year history of smoking a pack of cigarettes a day. He further testified:

"It's my opinion that Ms. Bryant's upper extremity symptomatology as well as pathology involving the median and ulnar nerve and/or cervical arthritis and/or cervical radiculopathy was not caused or aggravated by her employment activities at Tamms."

He based his opinion on the summation of his evaluation of Petitioner, her description of her job activities, the CorVel job site analysis, Major Markel's analysis, evaluation of the medical pathology, analysis of her medical records, and his discussion with Petitioner regarding the development of her symptoms and her description and understanding of her job activities. RX5.

On cross-examination, Dr. Sudekum testified that even if it was determined that Petitioner's description of her work activities was credible and accurate, it would not change his opinion with regard to causation. He agreed that the procedures performed by Dr. Lehman and Dr. Forget were indicated, but testified he had not seen opinions from either physician regarding causation so could not opine as to whether they disagreed with his own opinion on same. RX5.

On May 12, 2015, Petitioner was evaluated by Dr. David Robson of Comprehensive Spine Care, Respondent's Section 12 examiner with regard to her cervical condition. Dr. Robson noted an exhaustive list of medical records and documents he reviewed in conjunction with his examination. He obtained a history from Petitioner and conducted a physical exam. He noted that review of Dr. Hahn's records showed that the "records outline initial complaints in July with no mention of the cervical spine." Dr. Robson gave the following opinion:

> *"I have nothing to link what occurred on September 22, 2010, to the need for the surgeries as outlined above. Her symptoms were degenerative in nature....I cannot tell with any medical certainty that anything occurred on September 22, 2010, or that any repetitive nature of her job created the need for treatment that she has received....I do not feel there is a relationship between the patient's current findings and the reported accident. I do not feel any treatment is referable to anything that occurred around September 22, 2010, nor do I see any case for repetitive trauma."* RX6

Dr. Robson testified by way of deposition on April 26, 2016. He is a Board Certified Orthopedic Spine Surgeon. He testified consistent with his report. He noted Petitioner did not allege any kind of traumatic event that broke out all of her symptoms, but rather she stated this had occurred over time and she attributed it to repetitive work. Dr. Robson noted that the EMG/NCS of August 6, 2010, clearly showed the presence of early cervical radiculopathy. His diagnosis was that Petitioner suffered from cervical spondylosis, causing foraminal stenosis at the C4-5 level. Dr. Robson testified he did not feel there was anything in the medical records or job duties described that would aggravate Petitioner's underlying cervical condition. RX7.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989).

The Arbitrator notes that Petitioner put forth a theory of repetitive trauma in support of her claim that she sustained an accident that arose out of and in the course of employment. Illinois recognizes that a claimant's condition may not always arise out of a single incident of trauma and, thus, benefits may be awarded for repetitive trauma. However, even when repetitive trauma is asserted as a theory of accident, the employee must still show that the job duties were, in fact, repetitive. *See e.g. Williams v. Industrial Comm'n*, 244 Ill.App.3d 204 (1st Dist. 1993). 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 Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 529-530 (1987).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an accident which arose out of and in the course of her employment. In so concluding, the Arbitrator finds compelling that over the course of nearly four years Petitioner treated with an orthopedic surgeon (Dr. Lehman), a plastic and hand surgeon (Dr. Hagan), a neurosurgeon (Dr. Forget), and a pain specialist (Dr. Karshner), none of whom offered any causation opinion whatsoever. The only physician to do so was her family physician, Dr. Hahn.

In looking at the treating records from the four specialists, none of the histories provided by Petitioner contained any reference to her job or her work duties or any assertion that she believed her various conditions were caused or aggravated by her job. There is simply no mention of her work whatsoever.

With regard to Dr. Hahn's causation opinion, he conceded he was not very familiar with Petitioner's daily duties, had never reviewed a job description for a correctional officer position at Tamms, had never reviewed a job site analysis, and was not aware of how many job assignments there were for a correctional officer at Tamms. He was not aware of how long Petitioner had worked at Tamms. Dr. Hahn acknowledged that, in forming an opinion on causation, it would be helpful to know Petitoner's job duties, including the frequency, duration, and intensity with which she did those job duties. He conceded he did not know what shift or days Petitioner worked, or whether the officers rotated positions.

Dr. Hahn was aware that Petitioner took meals to inmates, but did not know the weight of the trays or the cart, and conceded it would be of benefit to know those things in determining whether it was a causative factor in her neck or upper extremity complaints. While he testified that this task would "most likely be repetitive" and that the frequency, not necessarily the weight, would be a factor, he conceded he did not know the frequency with which Petitioner was performing this job duty, and further conceded that fact would possibly be important in knowing whether it was a causative factor.

Dr. Hahn further acknowledged that he had no details with regard to the job duties of transferring inmates or paperwork. He did not know the type of doors or keys used at Tamms, how inmates were moved, or how many times a day Petitioner would turn a key. He again conceded that such information would be important in determining whether the duty was repetitive. He did not know how many times a day Petitioner passed the food trays and testified that he relied upon Petitioner's assertion that it was repetitive. With regard to working in the control room, Dr. Hahn testified that pushing buttons and turning knobs and switches would be considered repetitive and a risk for carpal tunnel syndrome. However, he did not know how many times Petitioner might perform those tasks and conceded that would be important in knowing whether her duties were repetitive.

The Arbitrator finds Dr. Hahn's opinion with regard to causation to be presumptive, to be based upon incomplete and/or inaccurate information, and thus to not be credible.

Conversely, both Dr. Robson and Dr. Sudekum had detailed information with regard to Petitioner's job as a corrections officer and her specific duties. Both gave reasoned opinions, based upon that information and upon the medical histories and conditions, that Petitioner's job duties did not cause or aggravate any of her conditions.

The Arbitrator finds the opinions of Dr. Robson and Dr. Sudekum to be well-informed as to the facts and thus to be credible and persuasive.

The Arbitrator further finds Petitioner's version of her daily job duties to be lacking in accuracy and veracity, when compared to Respondent's official Job Description, the Job Site Analysis, the Demands of the Job, and the testimony of witness Jason Hall. In addition, the Job Analysis shows that in the two years prior to her alleged date of accident, Petitioner was the Union President and performed daily duties which were even less hand-intensive. Further, for the two months immediately preceding her alleged date of accident, Petitioner was on a voluntary assignment to the Employee Commissary Area and her daily duties were primarily of a supervisory nature.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an accident on September 10, 2010, that arose out of and in the course of her employment with Respondent. All other issues are rendered moot and the Arbitrator makes no findings regarding same. All benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID PUCKETT,

Petitioner,

18IWCC0466

vs.

NO: 14 WC 13515

AG VIEW FS, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The arbitrator found Petitioner's stipulated accident on January 10, 2014 caused his conditions of ill-being of his spine at L1-2 and L5-S1. He awarded Petitioner 60&6/7 weeks of temporary total disability benefits and $341,489.88 in medical expenses. The Arbitrator also indicated the award was not a bar to an additional medical award on remand. In addition, the Arbitrator granted Respondent credit of $27,326.71 for paid temporary total disability and $50,243.37 for payments under §8(j). The Commission agrees with the analysis of the Arbitrator regarding the issues of causal connection and temporary total disability and affirms and adopts those aspects of the Decision of the Arbitrator.

As noted above, the Arbitrator awarded $341,489.88 in medical expenses. He awarded all expenses submitted by Petitioner in his exhibit based on a summary of medical charges apparently prepared by Petitioner's lawyer. Petitioner did not submit medical bills certified by the providers or issued pursuant to subpoena. The Commission finds that the award of medical expenses was improper. Without the protections afforded by certification, or being submitted pursuant to subpoena, the exhibit specifying the alleged expenses was inadmissible hearsay.

Therefore, the Commission vacates the Arbitrator's award of medical expenses. However, the Commission notes that because the instant claim was adjudicated pursuant to §19(b), this matter will be remanded for further adjudication. The Commission also notes that in his decision, the Arbitrator specifically indicated that Petitioner was not precluded from receiving additional medical on remand. Therefore, on remand the Arbitrator may consider awarding current medical expenses for which certified bills, or bills presented pursuant to subpoena, are submitted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $419.00 per week for a period of 60&6/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

18IWCC0466

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: JUL 25 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-7/12/18
46

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

18IWCC0466

PUCKETT, DAVID
Employee/Petitioner

Case# **14WC013515**

AG-VIEW FS INC
Employer/Respondent

On 9/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0507 RUSIN & MACIOROWSKI LTD
EVAN KLUG
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

1097 SCHWEICKERT & GANASSIN
MARK WILSON
2101 MARQUETTE RD
PERU, IL 61354

18IWCC0466

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
19(b)

David Puckett
Employee/Petitioner

v.

Ag-View FS, Inc.
Employer/Respondent

Case # **14** WC **13515**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Bloomington**, on **5/24/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **1/10/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$32,682.00**; the average weekly wage was **$628.50**.

On the date of accident, Petitioner was **54** 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 **$4,850.16** for TTD, **$0** for TPD, **$0** for maintenance, **$14,146.50** for advances on PPD, and **$8,330.05** for short term disability benefits, for a total credit of **$27,326.71**.

Respondent is entitled to a credit of **$50,243.37** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $341,489.88, as set forth in Petitioner's exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $50,243.37 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $419.00/week for 60 6/7 weeks, commencing 1/11/13 through 3/28/13 (11 weeks), 10/21/14 through 4/17/15 (25 4/7 weeks), and 12/6/16 through 5/24/17 (24 2/7 weeks), as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $4,850.16 for temporary total disability benefits that have been paid, $14,146.50 for advances, and $8,330.05 for short term disability benefits, for a total TTD credit of $27,326.71.

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

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

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

Michael K. Nowak, Arbitrator

9/19/17
Date

ICArbDec19(b)

SEP 29 2017

FINDINGS OF FACT

On 1/10/13, Petitioner was employed by Respondent as an equipment operator. He began working for the Respondent in April 2009. His job duties and responsibilities consisted of maintaining and operating equipment and spreading fertilizer. The machine he worked most with was a terra-gator, which was used to spread fertilizer.

On 1/10/13, Petitioner sustained an undisputed accident when he was installing a multiplier into the box on a terra-gator. The multiplier is an insert that goes into the box so it can spread two different fertilizers at the same time. Petitioner explained that he was inside the multiplier as it was being hoisted up with a chain hoist. There are two chains that are hooked to each corner that go through a loop on the inside of the multiplier. Petitioner pulled on the chain hoist raising the multiplier up while he was inside. While attempting to center the multiplier, one of the chains slipped off the main hook on the chain hoist causing one end of the multiplier to completely tip down. Petitioner testified that he went backwards against the box and then forward and then back again and then down inside the box. He was approximately 8 feet off the ground when the chain came off the hook. He came to rest at the bottom of the box. He described that when the chain came off he went back against the box and then forward so that his chest was at his knees in a completely flexed position. Upon coming to rest, he was in pain and could hardly talk. He didn't want to try to move. He testified that one of his co-workers called 911.

The Walnut Fire Department EMS arrived at the site while Petitioner was laying on his back in a grain hopper. (Px.2) Petitioner and co-workers explained that he was standing in a hopper lost his footing and fell striking his lower back on the edge of the hopper. He was immobilized with a C-collar and placed on KED board then loaded onto a long spine board inside the hopper and lifted out. He was taken to Perry Memorial Hospital. (Id.)

At the emergency room, a musculoskeletal exam indicated tenderness of the lumbar spine. (Px.2) He described his pain as dull, sharp, and constant located in the low to mid back. X-rays of the pelvis, thoracic and lumbar spine were taken. No acute traumatic abnormalities were noted. He was prescribed Naprosyn and taken off work. He returned the emergency room on 1/12/13 complaining of mid low back pain radiating to the right side. He described the pain as a level 10 that was aching, throbbing, and spasmodic. The pain was aggravated by movement, bending, walking, and coughing. He was diagnosed with a contusion, myofascial pain and strain/sprain of low back. He was prescribed Flexeril and Vicodin and kept off work until recheck on 1/15/13. (Id.)

On 1/15/13, he followed up with Dr. Arnold Faber who had seen him in the emergency room. (Px.2) Dr. Faber prescribed physical therapy, kept him off work, and ordered a lumbar MRI. (Px.3) A lumbar MRI performed on 1/29/13 showed acute to subacute non-displaced fracture of the spinous process of L1 with probable contusions of the spinous processes of L2 and L3. Moderate edema associated with a Schmorl's node in the superior endplate of L2, which may indicate an acute to subacute herniation. Small left foraminal disk protrusion at L3-4 minimally contacting the exiting left L3 nerve root. Mild disk bulge more prominent towards the right, mild right foraminal/far lateral osteophytosis, and mild facet hypertrophy at L5-S1 causing moderate right neuroforaminal stenosis impinging on the exiting right L5 nerve root. Upon reviewing the results of the MRI, Dr. Faber referred Petitioner to Dr. Snyder at IPMR. (Id.)

On 2/21/13, Petitioner saw Dr. Snyder who documented a history of an injury while working on 1/10/13. (Px.11) At that time, he was inside a box that was being lifted by a hoist. One of the chains broke and the box fell with him in it. He landed backwards with his back bending backwards over the edge of the box. He immediately had pain in the mid low back region. He states he is in physical therapy now. He describes his

pain as aching, sometimes stabbing, and at the highest is a level 6-7/10 on a pain scale. He states that he has been using Vicodin on average maybe two per day and will occasionally use over the counter Advil and Flexeril at night. There is no history of any back problems. He works as an applicator/operator and states that he has been told by his employer that they are not going to put him in that position this spring and will probably let him go back to it in the fall. Upon examination, he has some tenderness to palpation over the L1-L4 spinous processes. Mild paravertebral tenderness on the right and mild myospasm present. He appears to be a bit uncomfortable and shifts a lot in his chair. Prolonged sitting is uncomfortable for him. The impressions are L1 spinous process fracture, contusions L2-L3, Schmorl's node, and acute L2 herniation. Dr. Snyder recommended that he continue with physical therapy and renewed his prescription for Vicodin. He was kept off work and told to follow up in 4 weeks. (Id.)

Petitioner testified that in addition to receiving physical therapy he sought treatment on 2/25/13 at Carlson Chiropractic Clinic in hopes that it would reduce the amount of pain medication he was taking. The chiropractic records indicated a history on an injury at work on 1/10/13 when he was bent backwards over a piece of equipment he was working on and fell about 8 feet. (Px.4) His chief complaint is pain in the lower back area. Nights are especially difficult because he has to move every hour due to pain. He rated his pain as a level 5 out of 10. The symptoms have been present since the date of the injury. He describes the pain as stabbing, aching, sharp with movement, and deep. His symptoms are aggravated by driving. Dr. Carlson provided him with treatment consisting of manipulative therapy, acupuncture, and lumbar traction. (Id.)

On 3/28/13, Petitioner followed up with Dr. Snyder for his back pain. (Px.11) Dr. Snyder documented a history of an L1 spinous process fracture and contusions at L2-L3 as well as a Schmorl's node and acute herniation at L2 that was related to an injury while working on 1/10/13. Petitioner rates his pain that ranges from a level 2 or 3 out of 10. He used Advil a few times per week and Vicodin maybe 2 tablets per week. Dr. Snyder released him back to work full duty and noted "[h]e states that they will take care of any light duty initially without any recommendations from me." Dr. Snyder also prescribed Vicodin to use for additional pain relief and advised him to use the Advil before and after work as he moves back into the work force. (Id.)

Petitioner testified that as of 3/28/13 his back was still sore but that he was anxious to get back to work. He still required pain medication and continued to receive chiropractic treatment periodically as well follow up with Dr. Faber periodically. He testified that upon returning to work his co-workers were pretty good about helping him when needed. He further explained that they knew he was coming back from an injury and helped him a lot particularly with lifting, loading, chemical mixing and stacking.

On 6/13/13, Petitioner saw Dr. Faber for a recheck. (Px.3) It was noted that he was still having back pain that wakes him up in the middle of the night. The pain was described as mild to moderate with spasms. The clinical impression was post-traumatic back pain. He was prescribed Vicodin, Orphenadrine, and Tylenol. Dr. Faber refilled these medications on 9/6/13. (Id.)

Petitioner went to Carlson Chiropractic Clinic for a total of 29 visits from 2/25/13 to 12/17/13. (Px.4)

Petitioner testified that he continued to work requiring a lot of assistance from co-workers leading up to the repeat lumbar MRI recommended by Dr. Faber. On 1/13/14, Dr. Faber documented Petitioner's long standing back pain from one year ago that never fully resolved. (Px.3) The pain has been constant since the trauma and interferes with sleep, work, and household activities. Dr. Faber ordered a repeat lumbar MRI that was performed on 1/24/14. The MRI showed a large central disk extrusion at L1-2, displacing both L3 nerve roots and causing moderate central canal stenosis; and a mild disk bulge, small dorsal osteophytes, and slight

degenerative retrolisthesis at L5-S1 with a very small right paracentral disk extrusion with slight inferior migration. Upon reviewing the MRI results, Dr. Faber referred Petitioner to Dr. Smith. (Id.)

Petitioner saw Dr. Smith, a neurosurgeon, on 2/24/14. (Px.5) Dr. Smith documented a chief complaint of low back pain with complaints of stiffness, pain in the hips, numbness and pain in the legs, which have been present since January 2014. He describes severe pain in his lower back that extends down his proximal bilateral lower extremities that is sharp and electrical in nature. It is located in the frontal area of his proximal legs and prevents him from walking and farther than a quarter mile at which point his legs start to feel heavy. He has tried treatment with a chiropractor, traction, and NSAID's which have not been helpful. He works has a heavy equipment operator and did have a work related injury. He takes Vicodin, a muscle relaxant, and four Advil twice daily. He brings an MRI that shows primarily significant findings at L1-2 associated with central and bilateral lateral recess compression and an indentation of the thecal sac causing moderate to severe compression at L1-2. The L2-3, L3-4, and L4-5 levels do demonstrate evidence of mild degenerative disk disease and mild facet hyper trophy at L4-5 and L5-S1. He has radicular pain which appears to be just below the groin that would be consistent with an L2 distribution. Given the size of the disk herniation, he would be a candidate for a microdiscectomy. This L1-2 disk is causing significant mass effect and indents the thecal sac severely. He has had symptoms for many months that has become progressively worse over the last two months. The consultation with Dr. Smith was authorized by the workers' compensation carrier. (Id.)

Petitioner testified that Dr. Smith did not perform the surgery once he realized it was a workers' compensation case.

On 4/29/14 Petitioner was examined by Dr. Thomas Gleason pursuant to section 12 of the Act. Dr. Gleason's findings and opinions are discussed below.

Dr. Faber referred Petitioner to Dr. Mather, an orthopedic surgeon. (Px.3) On 8/4/14, Petitioner saw Dr. Mather. (Px.6) The history of present illness indicated Petitioner was injured on 1/10/13 falling into a grain hopper. He lost his footing and caught his lower back on the edge of the hopper, falling approximately 6-8 feet. He gradually improved to some degree and had some chiropractic treatment, but was never "quite right". He was noted to have had an initial MRI which showed a tearing of the L1-L2 interspinous ligament, a contusion to the top of L2, and a tear in the posterior longitudinal ligament. He eventually went back to work a couple months later and states he was concerned about losing his job. He complained of thoracolumbar pain that radiates to the lower back with intermittent numbness sensation in both legs and pain in the front of both thighs. He has continued working as he is concerned about possibly losing his job or being replaced if he does not show up to work. He takes two Norco per day and has been doing that since approximately June of last year. Upon examination, he has some mild tenderness at the thoracolumbar junction. He has increased pain with extension or flexion although overall range of motion is probably 80% to 90% of normal. As to urinary symptoms, he will occasionally have severe urgency and have to urinate "right away". His last MRI of 2/19/14 showed a large L1-L2 disk herniation. The impression is herniated disk, L1-L2 with flexion injury to the L1 segment. Dr. Mather indicated that it would be technically difficult to address this herniation without a facetectomy since the lower end of the thoracic cord is so close to the area of surgical decompression. Therefore, a unilateral facetectomy a discectomy and stabilization/instrumentation fusion of the segment is recommended. He recommended a repeat lumbar MRI since the previous MRI is nearly 8 months old. He further recommended Petitioner only work with a 5-10 pound lifting restriction as he is at high risk for cauda equina syndrome if the herniation enlarges to any significant degree. It was stressed that he should not delay the surgery because he is at high risk should the herniation enlarge. (Id.)

On 8/12/14, a repeat lumbar MRI showed findings unchanged at the L1-2 level compared to the 1/24/14 MRI. (Px.6) At the L5-S1 level it showed a small right paracentral disk extrusion mildly increased in size, now contacting and mildly displacing the traversing right S1 nerve root as compared to the prior study. Other findings at L5-S1 are unchanged. On 10/13/14, Dr. Mather reviewed the repeat MRI and scheduled Petitioner for surgery. He also continued him on Norco 3-4 tablets per day. On 10/21/14, Dr. Mather performed surgery consisting of a laminectomy L1-L2 with bilateral complete facetectomies, decompression of L1 and L2 nerve roots; L1-L2 posterolateral fusion; titanium pedicle screw system L1-L2 with Biomet/Lanx cross connector; and local bone graft, allograft and infuse. Petitioner testified that he was taken off work as of the 10/21/14 surgery. (Id.)

On 11/7/14, Petitioner followed up with Dr. Mather. (Px.6) He has some bilateral buttock pain but it is more of an achiness. He is still requiring Valium to sleep at night but overall feels like he is making some progress. He is currently off work. On 12/12/14, it is noted that he is slowly getting better and his leg pains are gone. He is wearing his back brace. He has no tenderness to the back, but any pain he does get appears to be to the mid to upper lumbar area. As of 3/13/15, Dr. Mather documented continued pain. He feels good if he is wearing his brace. He is not taking any narcotics at this point. His neuro exam shows some numbness in the high buttock areas bilaterally but nothing into the groin and bilateral legs. He can extend approximately 20 degrees and flex forward approximately 50 degrees. Both movements cause a very tight feeling in the lumbosacral area. There is minimal tenderness in the thoracolumbar area. We will start him on aggressive physical therapy then work hardening because he would like to get back to work by April 18. (Id.)

Petitioner started physical therapy on 3/17/15. (Px.2) The frequency of physical therapy was 2-3 times per week for 6 weeks. As of 4/16/15, Petitioner's back index score was 38, which was indicative of moderate disability. (Id.)

On 4/17/15, Dr. Mather indicated Petitioner was doing relatively well in physical therapy. (Px.6) He has no leg pain and is taking no pain medications. Upon physical examination, he has a little bit of right sided L5-S1 tenderness and some mild pain in this area with range of motion but no obvious sciatica. His impression was low back syndrome with degenerative disk disease. Dr. Mather released him to return to work with a 20 pound lifting restriction and no excessive bending or twisting. (Id.) He was discharged from physical therapy. (Px.2)

Petitioner testified that his employer indicated that they could accommodate his restrictions. His back was still sore, but he was anxious to go back to work. He testified that upon returning to work his co-workers would assist him as needed much the same as it was when he was working prior to the surgery. He indicated that he was still taking pain medication and continuing to follow up with Dr. Mather.

On 7/9/15, Petitioner was seen by Dr. Faber who indicated that although he was back to work and doing fairly well he still requires Hydrocodone for adequate pain relief. (Px.7) His assessment was chronic lumbar back pain. (Id.)

On 7/17/15, Dr. Mather documented that Petitioner is feeling great. (Px.6) He does have some lumbosacral-type stiffness, but there are no radicular complaints. He is basically back to regular work, although he does watch when he has to do any heavy lifting and he is avoiding riding in one of the machines that causes a lot of bouncing. His residual symptoms are likely coming from his lumbosacral disk at L5-S1. His surgery at L1-L2 has been successful. On 8/24/15, his chief complaint is noted to be low back pain and bilateral thigh pain. He is having more and more lower back pain when asked to use heavy machinery at work. He has difficulty bending over and takes Flexeril every night for sleep. He is not having any symptoms that he had

from his L1-L2 surgery. Upon examination, he has pain at the lumbosacral junction with flexion to approximately 30 degrees and has pain when coming up from a bent over position. His pain appears to be all localized to the L5-S1 segment. Previous x-rays revealed marked collapse at L5-S1. The impression is L5-S1 degenerative disk disease with radiculopathy. Due to the chronicity of the pain, and MRI of the lumbar spine was recommended. At some point, this may require an L5-S1 fusion. A lumbar MRI performed on 9/3/15 showed a prominent right lateral disk protrusion at L5-S1. Disk material extends into the right L5-S1 neuroforamin. There is also a moderate diffuse disk bulge and moderate facet joint hypertrophy. (Id.)

On 9/30/15, Petitioner attended a DOT physical to renew his CDL. (Px.7) It was noted that he takes Vicodin for back pain at night. (Id.)

On 1/18/16, Petitioner followed up with Dr. Mather. (Px.6) He reported that he is working as best he can and basically watches how much he has to lift. He feels like the lower back pain is limiting what he can do in terms of work and regular activities of daily living. On examination, he has pain with both flexion and extension, but extension is much more severe. He has a positive straight leg raise bilateral at 50 degrees causing radicular pain down the left leg. Dr. Mather reviewed the September 2015 MRI and indicated that it shows progression of disk degeneration at L5-S1 since the work injury and 2013 MRI. He has bilateral foraminal stenosis at L5-S1. His impression was symptomatic L5-S1 degenerative disk disease with foraminal stenosis causing back and leg pain. He recommended a lumbar fusion. Petitioner indicated that he would like to do this during the winter season as he has financial concerns about doing it currently. He was prescribed Norco for pain and will follow up in September to schedule the surgery in November. He may continue within his own limitations at this point. (Id.)

Dr. Mather authored a letter to Petitioner dated 1/18/16 in which he indicated Petitioner has ongoing degenerative disk disease at L5-S1 that was injured in 2013 in conjunction with a L1-2 herniation. (Px.6) The L1-2 herniation was surgically treated first as it was much larger. The L5-S1 disk has remained symptomatic and now requires laminectomy and fusion. Dr. Mather opined that as the L5-S1 disk was asymptomatic prior to the 2013 fall, it was a work related injury. (Id.)

On 4/14/16, Petitioner was seen by Dr. Faber who indicated Petitioner has chronic back pain as a result of a devastating fall and back injury. (Px.7) He further indicated that although surgery has helped, he is never pain free. He refilled his Hydrocodone prescription. On 7/22/16, Dr. Faber again refilled his medication for chronic pain. (Id.)

Petitioner followed up with Dr. Mather on 9/12/16. (Px.6) He reported continued chronic lower back pain. On exam, he had reduced range of motion of the lumbar spine. The impression was lumbar degenerative disk disease at L5-S1 with superimposed central disk herniation. A repeat MRI was ordered that showed moderate bilateral neuralforaminal narrowing at L5-S1 related to encroaching L5-S1 disk. The findings were similar to the previous study of 9/3/15. (Id.)

Petitioner saw Dr. Faber on 11/1/16 for pre-op clearance. (Px.7) His neurological exam was positive for numbness, paresthesias, and tingling due to back injury. He was cleared for surgery. (Id.)

On 12/6/16, Dr. Mather performed surgery consisting of an L5-S1 facetectomy, L5-S1 minimally invasive transforaminal lumbar interbody fusion instrumentation and cage, allograft. (Px.8)

Petitioner testified that leading up to the surgery he continued to work with assistance provided by co-

workers as needed. He was taken off work as of the date of the surgery.

Petitioner continued to follow up with Dr. Mather's office and was noted to be doing well overall. (Px.6) As of 1/30/17, he was still taking up to 3 Norco a day for low back discomfort. He was wearing his brace faithfully and denied any pain, numbness, or tingling into the lower extremities. It was recommended that he start physical therapy. (Id.) Petitioner started physical therapy on 2/2/17. (Px.7) As of 3/13/17, he reported that he has low back discomfort without leg pain. He continued to take 2 Norco a day and is participating in physical therapy. (Px.6)

Petitioner testified that he received a certified letter dated 3/17/17 from Respondent's general manager indicating that he must provide a doctor note by 3/29/17 authorizing him to be off work and the date of his next follow up visit or date of unrestricted return to work. (Px.13) In response to receiving this letter, Petitioner testified that he contacted Dr. Mather's office and was provided a letter dated 3/20/17 indicating Petitioner is to continue to be off work until 4/10/17. (Px.14) As of 4/10/17, he can work with lifting restrictions of 20 pounds maximum. If employment is not available with this restriction, he must remain off work completely. (Id.)

Petitioner testified that his employer indicated that they were not able to accommodate the restrictions and that they did not want him to return to work until he 100 percent.

On 3/31/17, Petitioner followed up with Dr. Faber who indicated his condition was improved but he still required medication for back pain. (Px.7) It was noted that his activities of daily living were limited. Upon musculoskeletal examination, he had some restricted flexion of the lumbar spine and lateral bending. The impression was chronic back pain. He was prescribed Hydrocodone as needed 3 times a day. During physical therapy on 4/17/17, Petitioner reported mild lower back pain. He indicated that he performs activities at home slowly and with breaks. (Id.)

In describing his current condition, Petitioner testified that his back is better but he still has pain. He continues to take Vicodin a couple times a day. He is still doing physical therapy 3 times a week. His next appointment with Dr. Mather is on June 12th.

Respondent called Angela Lucas, HR Manager, as a witness. Ms. Lucas confirmed that Petitioner had not filed any subsequent claim or accident following the 1/10/13 accident.

Respondent also called Petitioner's direct supervisor, Jeffrey Monier. Mr. Monier testified that he is the location manager and is familiar with Petitioner's day to day job performance. He testified that Petitioner worked to the best of his ability when he returned to work following the accident. There were some things that his injury would not allow him to do, like lift heavy stuff or drive some equipment. Co-workers would provide him with assistance if he needed it. After undergoing his first back surgery, Mr. Monier testified Petitioner returned to work light duty and was not able to operate a lot of the field equipment. He would perform lifting activities to the extent that his light duty restrictions would allow. He further testified that at some point Petitioner started to perform more of his regular job duties lifting materials that normal activity would allow. On cross-examination, Mr. Monier conceded that he had no direct knowledge of the Petitioner ever being formally taken off his light duty restrictions following the first surgery. He testified that upon his return to work on 3/29/13 Petitioner was still having difficulties from the accident and appeared to be in obvious pain and co-workers were good about providing him assistance when needed. He also testified that when Petitioner returned to work light duty in April 2015 Petitioner was still having back pain and that co-workers would assistance him throughout the work day as needed. He agreed that Petitioner has a strong work ethic. Upon re-direct, Mr.

Monier testified that he did not notice any improvement in Petitioner's condition from the time he first returned to work leading up to the first surgery.

Dr. Mather's evidence deposition was taken on 9/5/14. (Px.9) Dr. Mather is a Board Certified Orthopedic Surgeon who specializes in surgery on the spine. (Px.9, pp.3-4) Dr. Mather testified that he reviewed the Perry Memorial Hospital emergency room records from January 2013, Princeton Family Physician's records, Carlson Chiropractic Clinic records, records from Dr. Smith, and the film from the January 2013 MRI and the 1/24/14 MRI film. (Px.9, pp.6-8) The January 2013 MRI showed a contusion of the top of L2 which in laymen's terms is a bone bruise or mild compression fracture. He also had tearing of the posterior ligaments which were the L1-2 interspinous ligaments. He indicated this was a flexion injury of the lumbar spine. (Px.9, p.9) He explained that a flexion injury is the same type of movement as if you were bending down to touch your toes and the major forces are right at the end of the thoracic spine. This is a classic injury described in many text books where you get a compression at the very end almost like a whiplash type of mechanism. (Px.9, pp.9-10) Dr. Mather testified that his understanding of the work accident was that Petitioner apparently lost his footing, caught his lower back on the edge of a hopper, fell about 6 or 8 feet, and injured his spine. If you were to fall on the lumbar spine with the spine flexed, you would get this injury. There is no doubt that this was a flexion injury because this patient had a contusion to the L2 body and there is no way to get that with any other mechanism. (Px.9, pp.10-11) The 1/24/14 MRI showed a large disk herniation at L1-2 markedly compressing his cauda equina. He elaborated that the cauda equina is where all the nerve roots feather out from the base of the spinal cord and that causes neurologic symptoms as well as significant back pain. The sequela of the injury was to tear the back wall of the disk, allowing this fragment to come out later, similar to a rope climber hanging on a rope and somebody cuts part of the rope, he's able to hang on for a while but eventually the rest of the rope will tear later so this is the sequela of the original injury. The original injury being the 1/10/13 accident. (Px.9, pp.11-12) He indicated that the L1-2 disk herniation probably occurs in maybe 1 percent or less of all disk herniations. He stated that he probably performs 100 to 150 diskectomies per year and that he will see one L1-2 disk herniation maybe every other year. (Px.9, p.12) He diagnosed the Petitioner with an L1-2 disk herniation and flexion injury to the L1-2 segment. (Id.) He recommended a diskectomy facetectomy and fusion with instrumentation. (Px.9, p.13) He opined that the treatment received to date had been reasonable and necessary. (Px.9, p.15) On cross-examination, Dr. Mather testified that the Petitioner had a tearing of the posterior ligaments of the spine based upon his review of the actual films of the 1/29/13 MRI. (Px.9, p.31) He further explained that the tearing of the ligaments can be seen of the MRI because they bleed and the blood is shown on the MRI. (Px.9, p.33) On re-direct examination, Dr. Mather stated that he disagreed with Dr. Smith's recommendation for a diskectomy indicating that the proximity of the nerve roots is so close to the spinal cord warrants a fusion being performed to mitigate the chance of paralysis. (Px.9, p.35) He also testified that in his experience he has never seen an L1-2 herniation caused as a result of wear and tear and has only seen it as a result of some kind of significant trauma. (Px.9, p.36)

Dr. Mather's supplemental evidence deposition was taken 10/13/16. (Px.10) He testified that his current recommendation was for Petitioner to undergo an interbody fusion at L5-S1 to address both his degenerative disease and foraminal stenosis. (Px.10, p.15, 24) He opined that the need for the surgery is causally related to the January 2013 work accident. (Px.10, p.17) The basis of this opinion is that the work accident was a significant trauma. He has undergone an isolated disk resorption, which in laymen's terms involves the height of the disk being markedly reduced from 2013 to 2015. (Px.10, p.17) He reviewed the lumbar MRIs of 1/29/13, 1/24/14, 8/12/14, 9/3/15, and 9/16/16 and indicated that the MRIs started out with a herniated disk at L5-S1 and goes onto retrolisthesis and disk degeneration and then collapse of the disk causing the foraminal stenosis. He opined that the damage to the disk led to the collapse which is a phenomenon called isolated disk resorption that usually happens over about 18 months. (Px.10, pp.19-22) On cross-examination, Dr. Mather described the

Petitioner as not being a complainer and stoic. (Px.10, pp.31-32) He further stated that it's a rarity for a person to return to work within 6 months following a fusion as the Petitioner did. (Px.10, p.32) He testified that isolated disk resorption progresses in a rapid fashion consistent with the progression of Petitioner's condition. He explained that degenerative disk disease itself progresses very very slowly over decades. (Px.10, p.43) On redirect, Dr. Mather stated that the fact that the Petitioner returned to a labor job 6 months post-fusion surgery led him to believe that his complaints were valid because that is rarely seen. (Px.10, pp.48-49)

Dr. Gleason, Respondent's Section 12 physician, gave an evidence deposition on 5/26/15. (Rx.F) He is an orthopedic surgeon. (Rx.F, p.6) He testified that Petitioner had lumbar radicular syndrome. (Rx.F, p.16) He opined that as of the date of his first examination with Petitioner on 4/29/14 that no further chiropractic treatment would be of benefit. (Rx.F, p.17) He opined that a proposed L1-2 microdiscectomy was a reasonable consideration, but would be unrelated to the 1/10/13 accident. (Id.) He further opined that the Petitioner's condition as of 4/29/14 in terms of the extruded herniated disk at L1-2 was unrelated to the 1/10/13 accident based upon his knowledge and experience in addition to his review of the records and examination of the Petitioner. (Rx.F, p.18) He stated that he felt that the changes from the January 2013 MRI were most likely related to normal activities of everyday life influenced by genetics and heredity unrelated to the original injury. (Rx.F, p.22) He opined that the 1/24/14 MRI showed that a non-displaced acute to subacute fracture of the spinous process of L1 had healed and resolved. (Rx.F, p.23) On cross-examination, Dr. Gleason testified that he was not aware of any low back complaints or injuries by the Petitioner prior to 1/10/13. He also testified that he was not aware of any subsequent injuries or traumas to his low back after 1/10/13. (Rx.F, pp.36-37) He indicated that in his examination of the Petitioner on 4/29/14 there was mid and lower paralumbar tenderness on palpation and some groin pain bilaterally on rotation of the lower extremities. (Rx.F, p.38) He agreed that Petitioner's presentation as of 4/29/14 was consistent with the findings as set forth on the 1/24/14 MRI and that there was no indication of symptom magnification. (Rx.F, pp.40-41) As of that visit, Dr. Gleason recommended further neurosurgical and/or orthopedic spine follow up, consideration of an epidural steroid injection, a home exercise program, and over the counter medications or non-steroidal anti-inflammatory medications. (Rx.F, pp.41-42) He conceded that it is possible for an asymptomatic degenerative disk disease condition to become symptomatic from a trauma such as a fall. (Rx.F, p.43) He agreed that the surgery performed on 10/21/14 was reasonable and the fact that Petitioner returned to work in some capacity within 6 months of the surgery was indicative of a successful outcome. (Rx.F, pp.50-51)

Dr. Gleason gave a supplemental evidence deposition on 3/21/17. (Rx.G) He testified that he examined the Petitioner on 11/8/16. (Rx.G, p.7) He indicated that Petitioner had been working with restrictions since April 2015. (Rx.G, pp.8-9) He was continuing to use Vicodin 2-3 times daily. (Rx.G, p.9) He testified Petitioner did not participate in any hobbies, work related activities, or other circumstances contributing to his current symptomatology. (Rx.G, pp.10-11) Upon examination, there was tenderness on palpation of the lower aspect of the lumbar incision below and distally over the left lower paralumbar area. (Rx.G, p.12) He felt there was a lack of objective findings to support Petitioner's subjective complains. (Id.) An x-ray was ordered which he felt showed findings consistent with natural aging. (Rx.G, pp.13-15) He concluded that Petitioner could continue as before with his regular work, watching as it relates to heavy lifting at work and avoiding riding machines that cause a lot of bouncing. (Rx.G, p.19) He disagreed with Dr. Mather's interpretation of the MRI as showing a central herniated disk at L5-S1. (Rx.G, p.20) He opined that the L5-S1 fusion surgery recommended by Dr. Mather would not be reasonable and that Petitioner's L5-S1 condition was not causally related to the 2013 injury. (Rx.G, pp.21-22)

CONCLUSIONS

The parties stipulated and agreed that Respondent shall be given a credit of $4,850.16 for TTD, $14,146.50 for advances on PPD, and $8,330.05 for short term disability benefits, for a total credit of $27,326.71 in addition to a credit of $50,243.37 for medical paid.

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

It is not disputed the Petitioner sustained an injury to his back as a result of the 1/10/13 fall. Petitioner had no history of back problems or back injuries before the accident. Petitioner testified credibly that he began to feel pain immediately after the fall. The medical records demonstrate that from the initial treatment he received by EMS at the site of the fall through the date of hearing, Petitioner has consistently complained of low back pain.

Although Petitioner was returned to work full duty by Dr. Snyder on 3/28/13, Dr. Snyder in doing so noted "[h]e states that they will take care of any light duty initially without any recommendations from me." Dr. Snyder also prescribed Vicodin to use for additional pain relief and advised him to use the Advil before and after work as he moves back into the work force. (Px.11) Of significance, Dr. Snyder documented an L1 spinous process fracture and contusions at L2-L3 as well as a Schmorl's node and acute herniation at L2 that was related to a work injury on 1/10/13. (Id.)

Petitioner testified that as of 3/28/13 his back was still sore but that he was anxious to get back to work. He still required pain medication and continued to receive chiropractic treatment periodically as well follow up with Dr. Faber periodically, which is consistent with the medical records. He testified that upon returning to work his co-workers were pretty good about helping him when needed. He further explained that they knew he was coming back from an injury and helped him a lot particularly with lifting, loading, chemical mixing and stacking. He testified that he continued to work in this manner up until Dr. Faber recommended the repeat lumbar MRI in January 2014. In his 1/13/14 record, Dr. Faber documented Petitioner's long standing back pain from one year ago never fully resolved. (Px.3)

Upon reviewing the results of the 1/24/14 MRI, Dr. Faber referred Petitioner for a neurosurgical consultation with Dr. Smith that was authorized by Respondent's carrier. (Px.5)

Dr. Gleason, Respondent's Section 12 physician, opined as of 4/29/14 that surgery was a reasonable consideration, but would be unrelated to the 1/10/13 accident. (Rx.F, p.17) He stated that the changes from the January 2013 MRI were most likely related to normal activities of everyday life influenced by genetics and heredity unrelated to the original injury. (Rx.F, p.22)

Petitioner continued to work requiring assistance from co-workers as needed and taking pain medication. When Dr. Smith declined to perform the surgery due to the involvement of Workers' Compensation, Dr. Faber referred him to Dr. Mather who he saw for the first time on 8/4/14. Dr. Mather ultimately performed an L1-L2 fusion procedure on 10/21/14 and an L5-S1 lumbar fusion procedure on 12/6/16. (Px.6)

As to the L1-L2 condition, the Arbitrator finds Dr. Mather's opinions as to causation persuasive and credible. Dr. Mather personally reviewed the lumbar MRI film of 1/29/13 and indicated that there is no way to get a contusion to the L2 body with any other mechanism than a flexion injury. (Px.9, pp.10-11) He also testified that he has never seen an L1-2 herniation caused as a result of wear and tear (Px.9, p.36) as was suggested by Dr. Gleason. The consistent pain complaints documented throughout the records of Perry Memorial Hospital, Dr. Faber, Carlson Chiropractic, Dr. Snyder and Dr. Mather contradict Dr. Gleason's opinions that Petitioner's symptoms were most likely related to normal activities of everyday life influenced by

genetics and heredity. Petitioner had no history of back problems or back injuries before the 1/10/13 work accident.

As to the L5-S1 condition, the Arbitrator likewise finds Dr. Mather's opinions as to causation more persuasive and more credible than the opinions of Dr. Gleason. In particular, the Arbitrator notes that the 1/29/13 lumbar MRI report shows significant findings at the L5-S1 level consisting of mild disk bulge more prominent towards the right, mild right foraminal/far lateral osteophytosis, and mild facet hypertrophy at L5-S1 causing moderate right neuroforaminal stenosis impinging on the exiting right L5 nerve root. (Px.3) Subsequent MRIs of 1/24/14, 8/12/14, 9/3/15, and 9/16/16 showed a progression from a L5-S1 herniated disk to a collapse of the disk causing the foraminal stenosis consistent with Dr. Mather's testimony. (Px.10, pp.19-22) He stated that the rapid progression was consistent with isolated disk resorption from the original injury and explained that degenerative disk disease itself progressive very very slowly over decades. (Px.10, pp.19-22, 43)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the undisputed accident of 1/10/13.

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 findings and conclusions of the Arbitrator related to causation are adopted and incorporated herein.

The Arbitrator finds that the treatment provided to date has been reasonable and necessary including the L1-L2 fusion surgery performed on 10/21/14 and the L5-S1 fusion surgery performed on 12/6/16. As to the first surgery, it appears that the Petitioner obtained a successful outcome. As to the more recent L5-S1 surgery, Petitioner's symptoms have substantially improved from the surgery as he continues to progress through physical therapy.

Petitioner introduced evidence of medical expenses totaling $341,489.88. (Px.1)

In light of the above findings and conclusions the Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary. As such, Respondent shall pay reasonable and necessary medical services of $341,489.88, as set forth in Petitioner's exhibit 1, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $50,243.37 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The findings and conclusions of the Arbitrator related to causation are adopted and incorporated herein.

Petitioner claims entitlement to TTD from 10/11/13 to 3/28/13; 10/21/14 to 4/17/15; and 12/6/16 through the 5/24/17, the date of hearing.

The parties do not dispute the initial period of 10/11/13 to 3/28/13 and Respondent paid benefits during this period for which the parties have agreed it is entitled to credit. The remaining two periods, 10/21/14 to 4/17/15; and 12/6/16 through the 5/24/17 correspond to periods during which Petitioner was off of work due to

his surgeries on order of his treating physicians.

Having found the requisite causal relationship and that the treatment received was reasonable and necessary, the Arbitrator finds that Petitioner was temporarily totally disabled from 10/11/13 to 3/28/13; as well as from 10/21/14 to 4/17/15; and 12/6/16 through the 5/24/17 arbitration hearing.

Respondent shall pay Petitioner temporary total disability benefits of $419.00/week for 60 6/7 weeks, commencing 1/11/13 through 3/28/13 (11 weeks), 10/21/14 through 4/17/15 (25 4/7 weeks), and 12/6/16 through 5/24/17 (24 2/7 weeks), as provided in Section 8(b) of the Act. Respondent shall be given a credit of $4,850.16 for temporary total disability benefits that have been paid, $14,146.50 for advances, and $8,330.05 for short term disability benefits, for a total TTD credit of $27,326.71.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KARL SMITH,

Petitioner,

18IWCC0467

vs.

NO: 16 WC 31414

LEMASTER CONCRETE,

DECISION AND OPINION ON REVIEW

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

Petitioner sustained a stipulated work accident on April 8, 2016. The Arbitrator awarded Petitioner 75&6/7 weeks of TTD benefits, $548,380.23 in medical expenses, but he did not award medical expenses identified in PX32 because at that time "as a cause of the bilateral polyneuropathy has not yet been diagnosed and no causal connection yet confirmed as of the 19(b) hearing." The Arbitrator also granted Respondent credit of $9,662.09 for TTD benefits paid, $17,105.89 for payments under section 8(j), noted the award was not a bar for an additional medical award, and denied Petitioner's petition for penalties and fees. The Commission agrees with the analysis of the Arbitrator regarding the issues of causation, TTD, and medical expenses both current and prospective, and affirms and adopts those portions of the Decision of the Arbitrator.

18IWCC0467

As noted above, the Arbitrator granted Respondent credit of $9,662.09 for TTD benefits paid. However, upon questioning by the Commission at oral argument, the parties stipulated and agreed that Respondent actually paid $11,873.54 in TTD benefits. Accordingly, the Commission vacates the award of credit for TTD payments and modifies the award to reflect the amount of TTD benefits actually paid by Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $463.41 per week for a period of 75&6/7 weeks, through the date of arbitration, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $548,380.23 for medical expenses under §8(a) of the Act subject to the fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition for penalties pursuant to §19(k) and §19(l) and attorney fees pursuant to §16 is denied.

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 be given credit of $11,873.54 for TTD paid and payments of 17,105.89 made pursuant to §8(j).

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: JUL 25 2018

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

DLS/dw
O-7/12/18
46

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

18IWCC0467

SMITH, KARL
Employee/Petitioner

Case# **16WC031414**

LEMASTERS CONCRETE/CONSTRUCTION
Employer/Respondent

On 11/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.36% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 LAW OFFICE KEITH SHORT
1355 N BLUFF RD
UNITS C-D
COLLINSVILLE, IL 62234

0000 RUSIN & MACIOROWSKI LTD
MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Karl Smith
Employee/Petitioner

v.

Lemasters Concrete/Construction
Employer/Respondent

Case # 16 WC 031414

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **9/22/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **April 8, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**$17,512.00**; the average weekly wage was $**695.12**.

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

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

Respondent shall be given a credit of $**9,662.09** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**9,662.09**.

Respondent is entitled to a credit of $**17,105.89** under Section 8(j) of the Act.

ORDER

PETITIONER IS HEREBY AWARDED MEDICAL BILLS IN THE AMOUNT OF $548,380.23 AS SUBMITTED IN PETITIONER'S EXHIBITS 18 THROUGH 31 AND INCLUDING 33. PETITIONER'S EXHIBIT 32 IS NOT AWARDED AT THIS TIME AS A CAUSE OF THE BILATERAL POLYNEUROPATHY HAS NOT YET BEEN DIAGNOSED AND NO CAUSAL CONNECTION YET CONFIRMED AS OF THE 19(B) HEARING.

PETITIONER IS AWARDED TTD FROM 4/9/16 THROUGH THE DATE OF ARBITRATION, 9/22/17, AT THE RATE OF $463.41.

PETITIONER IS DENIED SECTION 16 ATTORNEY'S FEES AND PENALTIES UNDER SECTION 19(K) AND 19(L)

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

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

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

Edward Lee
Signature of Arbitrator

11/9/17
Date

ICArbDec19(b)

NOV 14 2017

STATE OF ILLINOIS
WORKERS' COMPENSATION COMMISSION

Karl Smith,	)	
	)	
Petitioner,	)	
	)	Case No: 16 WC 031414
v.	)	
	)	
LeMasters Concrete/Construction,	)	
	)	
Respondent.	)	

Arbitration Decision

Issues in dispute:
Causal connection, Medical bills, TTD, 19(k) and 19(l) penalties, attorney fees.

Facts:

Petitioner, age 41, is a heavy construction laborer. Specifically, he has spent the last 16 years as a concrete finisher. (T. 9) Concrete finishing involves regular bending and kneeling, lifting heavy hoses, redirecting wet concrete and considerable heavy lifting. Petitioner frequently has to use a large, heavy-duty hose to redirect wet cement from the mixing truck into basements, garage floors or into concrete colds. He then has to kneel to smooth the concrete or use hand implements and finishing brooms and tools. (T9-11). It is beyond refute that Petitioner's work constitutes heavy manual labor.

Petitioner testified that on 4/8/16 the hose he was using was a large diameter cement hose. Liquefied cement (slurry) would run from the mixer through the hose and then poured into the assigned area. When in operation, the hose would often weigh more than 30 lbs. Occasionally the hose would clog and the process would stop until the clog was cleared. There was a risk of hose rupture if the pumper was not stopped immediately. That was what occurred on the date of accident. The hose ruptured and the pressure of the erupting cement threw Petitioner into the air, twisted his body and caused him to land 15 feet away. Plainly speaking, it was a violent accident. Once Petitioner recovered himself from the explosion had noticed the immediate onset of agonizing low back pain and leg pain. Petitioner was taken from the job site by ambulance to St. John's Hospital in Springfield, Illinois.

The full medical history is discussed below. However, it is critical to note that Petitioner testified to a similar hose rupture occurred several years before the 4/18/16 accident. (T11-12) In the prior rupture Petitioner was hit in the face and shoulders causing the need for medical treatment. However, Petitioner did not file a Worker' Compensation Act claim for that injury. (T.12) He has never filed any sort of workers' compensation claim or civil liability lawsuit in his life. The instant claim was only filed when Respondent discontinued benefits; a situation described below.

Pre-accident medical:

Petitioner testified on direct examination that he had a history of occasional low back pain prior to the 4/8/16 accident. (T.12-13) Petitioner was equally forthright with all of the treating doctors throughout his care. No effort was made to hide his pre-existing low back injury. Prior to 4/8/16 Petitioner occasionally saw a chiropractor or medical doctor complaining of back stiffness and pain. (T.13) He had a few injections over a period of years. But, the record is clear that Petitioner never complained of persistent leg numbness, leg pain or lower extremity weakness prior to the accident in question. (T.13, Resp. exs) Also, it is unrefuted that prior to the instant claim Petitioner had never missed a single day of work as a consequence of low back pain, leg pain or any other work related ailment.

Respondent tendered exhibits 11, 12, 13, 14 and 15 as evidence of Petitioner's pre-accident medical treatment. Each exhibit is a selected portion of the medical record from various providers. On 10/5/11 Petitioner was seen at the St. John's Hospital ER where he was treated for a "right shoulder injury" which occurred while he was pouring cement and the hose became clogged. He had some, "mild neck and low back pain, his primary complaint is of right shoulder pain." Xrays of the lumbar spine revealed spondylosis. Despite having "severe" shoulder pain, Petitioner never filed a workers' comp claim and never lost time for this injury.

Respondent Ex. 12 is a 10/7/11 note from the Springfield Clinic. The note references the accident of 10/5/11. Petitioner complained of "very bad back and shoulder pain" subsequent to the concrete truck hose exploding. There is little in the way of back treatment and the focus of the care was the shoulder. There are no recorded complaints of leg numbness, weakness or tingling. There is no evidence that this injury caused Petitioner to lose time from work or require extensive care.

The most recent medical note presented by Respondent is the 2/19/15 note from Dr. Western. In that note Petitioner complained of back pain and discomfort in the buttocks when seated. He did not have any complaints of leg pain or numbness. Straight leg raising was normal and reflexes were normal. Petitioner was working secondary to a biceps injury (not work related) and did not have any limitations on work due to back pain or diminished capacity. (Resp. ex 15)

Medical treatment on and after 4/8/16:

After the hose explosion Petitioner was taken to St John's Hospital ER. An MRI was performed on 4/22/16. It was read as showing a central and lateral disc bulge at L5-S1 which abutted that anterior thecal sac and minimal disc bulges at L4-5. (Pet. ex 7) On 5/3/16 Petitioner was seen Dr. Payne at the Springfield Clinic on referral from Dr. McCay. (Pet ex 14) Petitioner was referred to physical therapy which he participated fully. In fact, Petitioner has regularly engaged in therapy from the date of injury, through his multiple surgeries and continuing through 8/20/17.

On 6/13/16 Petitioner was referred by Dr. Payne to Pain Consultants for epidural injections. Petitioner had multiple injections. (Pet ex 12) The note of 6/30/16 states that Petitioner had prior occasional low back pain, but had never had this level of debilitating pain until the accident of 4/8/16. Petitioner testified that the injections helped for a day or two but then the pain

returned. Dr. Salvacion also noted that Petitioner has pain extending into the right leg. This is a symptom that was never noted in any of the pre-accident history.

Dr. Payne referred Petitioner for an EMG/NVC to assess whether there was evidence of nerve entrapment. The study done on 7/20/16 was negative. However, both Dr. Raskas and Dr. Rutz testified that EMGs are very rarely used in assessing spine injury or nerve entrapment as they rarely are reliable.

On 8/2/16 Dr. Payne wrote that he was unable to identify the source of Petitioner's pain so he referred him to Dr. Van Fleet, an orthopedic surgeon. Dr. Van Fleet examined Petitioner and recommended work hardening on 8/26/16. He also indicated Petitioner was able to work light duty.

Petitioner had been receiving TTD until his light duty release and referral to work hardening. TTD was discontinued when Petitioner was released to light duty, however, the Respondent could not accommodate light duty. Respondent provided no explanation for why TTD was not paid. TTD was paid form 4/9/16 through 9/1/16 totaling 20 6/7 weeks.

Respondent offered video surveillance of Petitioner dated 8/4/16, 8/5/16, 8/6/16 and 8/25/16. This video was taken at a time Petitioner was released to work light duty with a 35lbs lifting restriction. The video shows Petitioner lifting a lawn mower out of his truck and mowing his mother's yard. The video shows Petitioner returning the mower to his truck. It also shows him picking up a small child. Petitioner appears to move normally, though slowly as he unloads and loads the mower. It was noted that the mower weighed approximately 30lbs and was self-propelled.

Petitioner testified that his wife did almost all of the work around the house and did most of the yard work since his injury. He felt he was allowed to mow since he was allowed to do light duty and since the exercises and lifting he was required to do in work-hardening were significantly more difficult than lifting a 2 year old or push mowing grass. (T. 32-33) Both Dr. Raskas and IME Dr. Rutz testified that they viewed the films and did not think the activity was inconsistent with light duty or suggested any inconsistent or inappropriate behavior on the part of the Petitioner. They also both testified that a person with Petitioner's particular injuries (discogenic back pain from annular tears) could participate in most activities of daily living. Petitioner testified that he was able to mow a few times but that it caused him considerable pain. (T.35) He also stated that mowing grass was not nearly as significantly heavy work as concrete construction which involves lifting 50-70 lbs and frequent bending and climbing. (T.36)

Petitioner saw Dr. Van Fleet on 8/26/16 and complained that he continued to have low back pain and pain radiating into his leg. Petitioner rated his pain as an 8 out of 10. He also complained to Dr. Van Fleet that he could not mow his yard. Petitioner testified that he told Dr. Van Fleet that he could not mow his yard without having significant pain and that most of the time his wife mowed the grass. Petitioner also told Dr. Van Fleet that he could not pick up his child. Petitioner confirmed that he told Dr. Van Fleet that he could not pick up his child, but clarified that he was referring to his 5 year old child, not his 2 year old child who weighed about 22 lbs. (T.32).

After the surveillance film Respondent obtained an IME with Dr. Lawrence Li, an orthopedic knee and shoulder specialist. Dr. Li wrote that he believed Petitioner suffered a lumbar sprain.

He further opined that Petitioner was at MMI and released him to return to work. No further care was offered by Respondent.

Petitioner returned to his regular physician, Dr. McKay and was referred to Dr. David Raskas, an orthopedic surgeon specializing in spinal surgery. (T. 26) On 11/18/16 Dr. Raskas took a history of injury and treatment and examined Petitioner. Dr. Raskas wrote that Petitioner had evidence of lumbar dysfunction which he felt was either caused or significantly aggravated by the accident of 4/8/16. Dr Raskas was aware of both Petitioner's pre-accident lumbar spine history and of the surveillance video.
Dr. Raskas ordered a discogram on 12/14/16 and CT discogram on 12/15/16. He felt both studies confirmed L4-5 and L5-1 annular tears and significant aggravation of spondylosis and arthritic development. Dr. Raskas continued Petitioner on light duty but felt that he would only improve once he had surgery. On 1/25/17 Dr. Raskas performed an anterior lumbar fusion at L4-5 and L5-1. During the surgery Dr. Raskas was able to observe an annular tear at L5-S1.

Several months after surgery Dr. Raskas arranged for lumbar spine injections by Dr. Rachel Feinberg on 3/14/16. Dr. Feinberg and Dr. Raskas placed Petitioner on a variety of pain medications, steroids and anti-inflammatory medications. Petitioner saw only nominal relief with injections and medications.

On 3/14/17 Petitioner had a repeat MRI of the lumbar spine. He also has a repeat CT of the spine and a myelogram on 3/21/17. Dr. Raskas felt that there was continued instability and recommended a posterior fusion. On 3/24/17 Petitioner had a posterior lumbar fusion at L4-5 and L5-S1.

After surgery Petitioner noticed a significant improvement in both his low back pain and leg pain. He testified that the surgeries eliminated his leg numbness and tingling and pain. He still has back stiffness and pain but it has greatly diminished.

On 4/18/17 Petitioner participated in another IME at the request of Respondent. Petitioner was sent to Dr. Kevin Rutz, a spinal surgery specialist. Dr. Rutz examined the entire medical history and agreed with Dr. Raskas that the MRIs and CT discogram showed a surgical pathology and that the need for surgery was directly related to the accident of 4/8/16. Dr. Rutz did not believe the negative EMG was of any significance. Dr. Rutz felt that the accident either caused Petitioner's injury or substantially aggravated his occasional low back pain such that it became more intense and chronic. In a supplemental report requested by Respondent's counsel, Dr. Rutz indicated that he reviewed the surveillance videos and did not believe they were significant to the issues of causation or the need for surgery. In his testimony Dr. Rutz reiterated that position.

Analysis:

Petitioner presents credibly in his appearance at arbitration; he is not overweight, not diabetic, does not smoke and has never had a workers' compensation claim or civil lawsuit prior to the instant claim. There are no glaring omissions in his medical history. He was forthright and openly acknowledged to all medical providers, including the ER personal and the IME physicians, that he had a history of occasional low back pain that pre-dated the accident of 4/8/16. He also advised all of the doctors that he had a history of chiropractic care and had at

least one lumbar injection prior to this claim. When Petitioner was observed mowing grass, lifting the mower and lifting his two year old child it has to be recognized that those activities were within the light duty and lifting limitations provided by his treating physicians and well below his work hardening exercises. Both spinal surgeons who testified in this case felt that the activities on surveillance were well within the light duty work limitations ordered for Petitioner. Accordingly, Petitioner's candor and, moreover, his veracity, cannot be seriously questioned.

In addition to Petitioner's credibility, there are two other factual certainties in this claim: 1) the accident Petitioner suffered was extraordinarily traumatic. He thrown at least 15 feet across the work site and had to be taken by ambulance to an emergency room. That sort of explosive force can easily be expected to cause or significantly aggravate a lumbar spine injury. And, 2) there is no evidence that Petitioner had a debilitating or significant low back injury prior to 4/8/16. Petitioner had never missed a day of heavy labor work before this accident (even when he survived a prior hose explosion). Further, there is no evidence in any of the records that Petitioner had right leg pain and numbness prior to the instant claim.

Respondent offered the testimony of Dr. Lawrence Li, an orthopedic surgeon who, by his own acknowledgement, specializes in shoulders, hands and knees. He is not a spine surgeon. Dr. Li testified that Petitioner suffered a lumbar sprain as a consequence of the accident but that he did not need surgery and could be released to return to work without restrictions. Dr Li testified that no orthopedic surgeon would recommend surgery for Petitioner's lumbar spine. However, Dr. Li was unaware that Petitioner had seen Dr. Raskas, a spine specialist who had recommended surgery. Dr. Li was also unaware that Respondent's other IME physician, Dr. Rutz (also a spine surgery specialist) agreed with Dr. Raskas that Petitioner was injured in the April accident and that Petitioner needed a lumbar surgery.

The Arbitrator does not find Dr. Li to be persuasive. He is not a spine surgeon, he is a knee and shoulder doctor. Dr. Li does not perform spine surgery and has not participated in a spine surgery since his residency. Dr Raskas and Dr. Rutz are both spine specialists and both concur on all of the issues of causation and need for surgery. Even more compelling, both spine surgeons testified that the activities Petitioner was performing on the surveillance video were consistent with his physical limitations and did not impact their respective opinions on causation and the need for surgery.

The testimony of Dr. Raskas and IME physician, Dr. Rutz is most persuasive. Both doctors agreed that the force of the accident was more than adequate to injure or permanently aggravate Petitioner's lumbar spine. Dr. Raskas testified that the MRIs showed "foraminal stenosis in the subarticular area narrowing slightly more on the right than on the left at L4-5, severe foraminal stenosis at L5-S1 with end plate changes and severe collapse of the disc space at L5-S1." (Pet ex 1, pg. 9). He confirmed the location and extent of the injuries with a CT discogram on 12/15/16. The discogram showed that Petitioner had, "a classically positive annular tear at L4-5 and L5-S1." (pgs. 11-12). Dr. Raskas explained in detail why the CT discogram was a more reliable and more precise device for assessing spinal pathology. (pgs. 12-13). Dr. Raskas confirmed that the discogram reproduced responses that were consistent with Petitioner's subjective complaints.

During the surgery on 1/25/17 Dr. Raskas removed the discs at the effected levels and inserted titanium cages with a posterior facet fusion. He also testified that he "noted there was an annular or central tear as I removed the disc at L5-S1." (pg 14) He testified that the findings in

the surgery were consistent with Petitioner's complaints. When asked about the negative EMG Dr Raskas confirmed that even in cases where there is an obvious injury on MRI and there is objective evidence of radiculopathy, the EMGs are negative up to 50% of the time. (p. 19)

Dr. Raskas confirmed Petitioner would have been temporarily totally disabled as of the day of the surgery. Prior to that time he would have allowed Petitioner to continue on light duty or sedentary duty. When asked about the surveillance video Dr. Raskas testified that the mowing, lift of the mower and other actions were "consistent with exactly what he told me." "He told me that he could do yard work on a periodic basis and that he would pay for it the next day." (pg. 22) Dr. Raskas did not believe the activities shown on surveillance had any bearing on the issues of causation or need for surgery.

Regarding the issue of causation, Dr. Raskas was adamant that there was a causal connection between the accident of 4/8/16 and the need for surgery. He testified, "My opinion is that the accident aggravated the degenerative process in his back causing it to become permanently symptomatic and where in the past he may have had some occasional back pain from this degenerative process this type of trauma was too much for him to recover from and he has continued to have a problem ever since then. (p. 18)

Petitioner testified that, while he continues to have some back pain, the leg pain was completed resolved after the surgeries. Prior to the surgeries he had "a lot of pain going into my right buttocks and down my right leg to my feet." (T.29) He believed the surgeries were able to address the symptoms that arose immediately after the accident and which persisted throughout the care in Springfield. (T.29-30) Petitioner has not been released to return to work by Dr. Raskas as of arbitration.

The only other testifying spine surgeon was Dr. Kevin Rutz, Respondent's IME physician. Dr. Rutz is a board certified spine surgeon who performs 90% to 95% of his IMEs at the request of Respondent's. (Pet. ex 2, pg. 6). Dr. Rutz saw Petitioner on 4/18/17. Dr. Rutz testified that he reviewed medical records both predating and subsequent to the accident of 4/8/16. (pg. 7) He agreed that none of the pre-accident medical records suggested Petitioner was a spinal surgical candidate nor that he had lost any time from work as a consequence of low back pain. Dr. Rutz reviewed all of the records from St. John's Hospital, Dr. Payne, Dr. Salvacion, the EMG, the MRI of 1/29/13 and 4/22/16 (predating and post-dating the accident), the records of Dr. Raskas and the CT, MRI and discogram ordered by Dr. Raskas. (pg.7-8). He testified that the discogram confirmed annular tears at L4-5 and L5-S1. (pg. 9). Dr. Rutz also had a detailed understanding of the accident both from analyzing the records and from discussing it with the Petitioner. (pg. 9-10)

Dr. Rutz noted that Petitioner had a significant benefit from the surgeries and felt he (petitioner) had much improved. (p. 10) Dr. Rutz testified, "I believe the accident caused the injury at L4-5 and most likely aggravated the preexisting degenerative condition at L5-S1." (pg. 11) He agreed that the surgeries performed by Dr. Raskas was reasonable, necessary and related to the 4/8/16 accident (pg. 11) and that Petitioner was not at MMI. (12)

Dr. Rutz also testified regarding the surveillance videos. After watching the videos he stated that what he observed, "didn't change my opinion." Regarding causal connection or the need for surgery. (p. 13) He added that with, "people with discogenic back pain, often video surveillance is not helpful unless the patient clearly can't do a number of things at all, and then

the video shows something that directly contradicts that." (p. 13) When asked about the notion that Petitioner was engaged in yard work despite saying he was having trouble doing yard work, Dr. Rutz testified, "[p]eople can do—they'll do things and they might feel it later on, or some days they can do it and some days they can't, which is not the same thing as being—having a normal spine and being able to do it without any consequences." (pg 13-14)

When pressed on cross-examination Dr. Rutz refused to change his opinions that the accident caused a tear and aggravated the degenerative conditions in Petitioner's lumbar spine. (pg. 16-17). He also reiterated that after the accident Petitioner should have been able to perform activities of daily living right up until the day of the surgery which included yard work. (pg. 18-19) even if that yard work caused a temporary flair up of symptoms (pg. 21 and 23)

Finally, about a month after surgery Petitioner developed numbness and tingling in the tops of both of his feet. (T.31) He has had evaluations of this condition by Dr. Gelber, a neurologist at the Springfield Clinic. He also had EMG/NVC by Dr. Trudeau. (Pet ex.17). While there is evidence of polyneuropathy in his feet, the records are devoid of a clear diagnosis or explanation for this condition. (T.32)

Findings and Award:

The issues in dispute are: Causal connection, Medical bills, TTD, 19(k) and 19(l) penalties, attorney fees.

Causation. In regard to the issue of causation, for the reasons stated above, the Arbitrator finds Petitioner has proved that the accident caused his need for the surgeries and further treatment performed by Dr. Raskas and hereby awards Petitioner the medical bills of $548,380.23 as submitted in Petitioner's exhibits 18 through 31 and including 33. Petitioner's exhibit 32 is not awarded at this time as a cause of the bilateral polyneuropathy has not yet been diagnosed and no causal connection yet confirmed as of this is a 19(b) hearing. Respondent is given a credit for any and all bills it has paid, subject to the Fee Agreement.

TTD. In regard to the issue of temporary total disability benefits, for the reasons stated above, Petitioner is awarded TTD from 4/9/16 through the date of arbitration 9/22/17. The parties agree that Respondent has paid TTD at the correct rate of $463.41 from 4/9/16 through 9/1/16 totaling 20 6/7 weeks. Respondent is hereby ordered to pay TTD from 9/2/16 through 9/22/17 equaling 53 weeks.

Penalties and Attorney Fees. In regard to penalties and attorney's fees the Arbitrator finds Respondent made a good faith argument that they had reasons for terminating TTD benefits and refusing to pay medical bills based on the surveillance and the opinion of Dr. Li. Therefore penalties and attorney fees are denied.

STATE OF ILLINOIS

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

Christian Ricco,
Petitioner,

vs. No. 14 WC 34216

18IWCC0468

Eby-Brown Company,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by Respondent and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, and prospective treatment, and being advised of the facts and law, modifies the Arbitrator's decision of November 18, 2016 as stated herein and otherwise affirms and adopts the Arbitrator's decision, which is attached hereto and made a part hereof. As discussed further below, the Commission: (1) vacates the Arbitrator's finding of causal connection between Petitioner's employment and the condition of ill-being in his elbows, insofar as Dr. Rhode expressly offered no opinion regarding same; and (2) finds Petitioner was no longer temporarily totally disabled by June 9, 2016, the date when video surveillance demonstrated him to be working for another employer (for cash). The Arbitrator's award of prospective left shoulder surgery is affirmed. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill. 2d 327, 399 N.E. 2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner, a 36-year-old truck driver, alleged injuries to both shoulders and elbows with a date of loss of August 15, 2014. The Arbitrator decided favorably for Petitioner and awarded: (1) medical expenses including for right shoulder surgery performed on October 13, 2015 by Dr. Blair Rhode; (2) prospective surgery to the left shoulder as recommended by Dr. Rhode; and (3) compensation for temporary total disability (TTD) for two periods: (i) August 21, 2014 through September 10, 2014, and (ii) October 13, 2015 through September 11, 2016 (a total of 50 and 6/7 weeks, miscalculated in the Arbitrator's decision as "53 and 6/7 weeks").

At trial, the parties stipulated that Petitioner sustained a work-related accident; Respondent disputed liability on the basis of causal relationship as to current condition of Petitioner's ill-being. On review, Respondent does not dispute medical expenses as to the right shoulder. Respondent takes exception to the Arbitrator's decision primarily as it relates to the left shoulder claim.

1. FACTUAL BACKGROUND

Petitioner was employed by Respondent as a delivery truck driver from January 2012 to September 2014. He made deliveries via semi-truck to gas station convenience stores. He described his on-the-job physical activities as including pulling out the ramp at the back of the trailer, opening the trailer door, loading product onto a two-wheeled dolly, and wheeling the product into the store. Individual items to be loaded onto the dolly could weigh up to 60 pounds, and the total load on the dolly could be 200 pounds. (Tr. 19-21). Petitioner is right-hand dominant. (Tr. 42).

A few months prior to August 15, 2014, he started noticing pain in the shoulders, tightness on the insides of his elbows, and pain going down to his hands. (Tr. 21). On August 20, 2014, he provided notice of injury to Respondent by filling out an incident report, wherein he wrote:

> "Over the period of the past few months I have noticed discomfort in my shoulders and elbows due to work duties. On 8/15/14, I felt a strain in right shoulder while working."

(PX 2). Petitioner presented that day to the ER at OSF St. Mary Medical Center. Their records indicate "history of bilateral shoulder and elbow pain worsening since 8/15/14. Heavy lifting at work." The nurse wrote:

> "The incident occurred more than 2 days ago (most pain Friday 8/15/14). The incident at work (told me it is work related). The injury mechanism was torsion (lifting and twisting all day). Both (right much worse but they both hurt) shoulders are affected. The pain is moderate. The pain has been constant since onset. The pain does not radiate. He has other injuries (both elbows hurt). Associated symptoms include muscle weakness."

(PX 8). Right shoulder x-ray showed calcific tendinitis. X-rays of the left shoulder and both elbows were relatively unremarkable. He was diagnosed with right shoulder pain, left shoulder pain, and elbow pain. He was prescribed hydrocodone-acetominophen and provided with a sling for his right shoulder. (PX 8). Petitioner was off-work for three weeks, from August 21, 2014 through September 10, 2014. He returned to work at Respondent at that point and was terminated not long after.

Petitioner soon began treating with orthopedists at Midwest Orthopedics. In early September 2014, Dr. Brent Johnson wrote:

> "Patient is here today complaining of bilateral shoulder pain. He states that he has been having muscular aching in both of his shoulders for the past few months. His right shoulder he believes that he injured on 8/15/14 at work and he went to the ER on 8/20/14 where he was told that there was a chip in his bone and he was put in the sling."

(PX 3). Dr. Johnson's treatment of Petitioner's right shoulder included an injection, which provided significant but temporary improvement. Petitioner also underwent physical therapy from September 22, 2014 to October 22, 2014. A right shoulder MRI done on October 20, 2014 showed rotator cuff tendinosis, adhesive capsulitis, acromioclavicular arthritis, and findings consistent with a microinstability. (PX 4). On October 27, 2014, the option of right shoulder surgery was discussed. Petitioner declined surgery and was to return to work full duty (however, as mentioned already, his employment with Respondent was terminated in September 2014). On January 9, 2015, Petitioner returned to Dr. Johnson, who noted that Petitioner's right shoulder pain had worsened. Another injection was administered. (PX 3).

On March 9, 2015, Dr. Johnson noted that Petitioner was to undergo right shoulder surgery and an MRI for the left shoulder. The left shoulder MRI was done on May 23, 2015; the radiologist's impression was "possible tiny small intrasubstance" supraspinatus tendon tear. (PX 5). (Dr. Rhode would interpret the film as showing "partial thickness tear" of the supraspinatus and some AC joint arthrosis.)

During this period of shoulder treatment with Dr. Johnson, Petitioner also was seen by Dr. Mahoney of Midwest Orthopedics for bilateral elbow pain. Nerve conduction tests done on September 15, 2014 showed bilateral mild median nerve neuropathy. (PX 3). Dr. Mahoney assessed bilateral medial epicondylitis. Petitioner last saw Dr. Johnson on December 8, 2014, when Dr. Johnson indicated that elbow treatment would be deferred until the shoulder issue was resolved. Petitioner has not had treatment for his elbows since. (Tr. 27-28).

On September 9, 2015, Petitioner came under the care of Dr. Blair Rhode. (Tr. 48). Dr. Rhode has been treating both shoulders ever since. On October 13, 2015, Dr. Rhode performed right shoulder surgery (arthroscopic acromioclavicular decompression surgery and distal clavicle excision). (PX 6; PX 7). Petitioner underwent a brief period of physical therapy and received weekly TTD benefits following that surgery until early 2016.

As to the left shoulder, on January 13, 2016, Petitioner informed Dr. Rhode that his left shoulder continued to worsen. (PX 6). Dr. Rhode recommended surgery (arthroscopic subacromial decompression) for that shoulder as well. (PX 9 at 15). In his deposition of July 13, 2016, Dr. Rhode explained his recommendation for left shoulder surgery. Dr. Rhode continues to recommend this surgery. Currently, Petitioner treats his left shoulder through a home exercise program with a "Thera-Band" provided by Dr. Rhode's office. (PX 9 at 18-19).

Dr. Rhode placed Petitioner completely off-work beginning on October 13, 2015, the date of right shoulder surgery. According to Dr. Rhode, Petitioner reached maximum medical improvement (and could return to work) as to his right shoulder by 20 weeks after this surgery (that is, by March 1, 2016). (PX 9 at 23, 29-30). However, as Dr. Rhode explained, he extended Petitioner's off-work status for months beyond that because of Petitioner's condition his left shoulder, which was still awaiting approval for surgery. As of the date of Dr. Rhode's evidence deposition (July 13, 2016), Petitioner's off-work status was still being maintained.

On August 10, 2016, Petitioner returned to Dr. Rhode and requested that the doctor return him to work because Petitioner "needed to get back to work as to the fact that [he] had zero income, and [he] was unallowed [sic] to collect unemployment because [he] was on a no-work slip." (Petitioner's TTD payments had ceased in early 2016). So, effective that day, Dr. Rhode ended Petitioner's off-work

status and returned Petitioner to work under "modified restriction" of "not more than [lifting] 50 pounds repetitively… and no more than 25 pounds overhead." (Tr. 36-37). Dr. Rhode wrote in his records that Petitioner "continues to progress in his left sided symptomatology." The assessment that day was [left] shoulder pain, rotator cuff sprain and medial epicondylitis. (PX6). On the Request for Hearing form, Petitioner asserted entitlement to TTD through August 10, 2016.

On September 12, 2016, according to Petitioner's testimony, he started a job as a truck driver with an employer called Toops Trucking. (Tr. 53-56). Currently, Petitioner has ongoing pain in his left shoulder and has difficulty raising his arm above shoulder level. He still feels pain in both elbows as well, "the same as [he] did when the incident report was reported." (Tr. 38-39). The Arbitrator awarded TTD up through September 11, 2016 (a month more than what Petitioner initially requested).

The Respondent obtained and introduced video surveillance of Petitioner on the premises of a business called "Sparkie's Garage" in Knoxville during four days in mid-June 2016 (specifically, June 9, 10, 16 and 17). (RX 6). This video footage depicts Petitioner milling about, talking to customers, leaning inside a customer's car, etc. At hearing, Petitioner acknowledged he "hung out" and "helped out a little" with minor tasks at this auto shop business, but asserted he was "never on payroll." (Tr. 59-60). As well, Petitioner testified that, during his claimed period of TTD, he solicited and received "donations" for doing auto mechanic work for others in his home garage. (Tr. 63-65). He estimated that he worked on about one car per week. (Tr. 63-65).

II. EXPERT OPINIONS

A. Section 12 examiner Dr. Stephen Weiss

On June 22, 2015, Petitioner underwent a Section 12 examination by Dr. Stephen Weiss. (PX 10). Petitioner reported pain in both shoulders and both elbows, but his most significant pain was in the right shoulder. The right shoulder pain was constant and made worse with overhead activities. In contrast, "his left shoulder and both elbows are not constantly pain, but will become symptomatic with significant use." (PX 10 at 4). Petitioner also told Dr. Weiss that he "lost his job in about September 2014, he has done some seasonal work since, although he is not currently working." Dr. Weiss diagnosed right rotator cuff tendinosis with acromioclavicular arthritis, as supported by MRI findings and physical examination; Dr. Weiss believed surgery would be appropriate. (PX 10 at 7-8). As to the left shoulder, Dr. Weiss wrote, "a diagnosis is premature as an MRI is pending, but I suspect rotator cuff tendinosis." Dr. Weiss recommended an MRI for Petitioner's left shoulder, following which further treatment could be discussed. (PX 10 at 7-8). A left shoulder MRI had been done on May 23, 2015; apparently it had not been forwarded to Dr. Weiss. (PX 5).

Dr. Weiss opined Petitioner's left (and right) shoulder complaints were work-related: "Mr. Ricco relates a specific incident of shoulder pain while lifting heavy objects, but he also reports that he does a lot of heavy lifting, including overhead lifting on his job, which appears to be supported by the provided Job Description. Therefore, I believe his current shoulder complaints and need for treatment should be considered work related." (PX 10 at 7).

18IWCC0468

B. Dr. Blair Rhode, treating surgeon

Dr. Blair Rhode sat for evidence deposition on July 13, 2016. (PX 9). Dr. Rhode provided favorable causation opinions for Petitioner as to both shoulders. Dr. Rhode's current diagnosis for Petitioner's left shoulder is left rotator cuff tendinopathy. (PX 9 at 16-17). As noted above, Dr. Rhode first recommended left shoulder surgery in January 2016 and testified in July 2016 that surgery was indicated because conservative measures had been exhausted. (PX 9 at 26-28). When questioned regarding Petitioner's elbows, Dr. Rhode stated that he had no opinion. (PX 9 at 20).

III. DISCUSSION and CONCLUSION

As to the Petitioner's left shoulder condition, the Commission affirms the Arbitrator's decision as to causation and need for the prospective treatment recommended by Dr. Rhode. It is significant that even Section 12 examiner Dr. Weiss opined that Petitioner's bilateral shoulder conditions were related to his job activities. However, Petitioner has so far provided no evidence that the current condition of ill-being in his elbows is so related. The Commission therefore vacates the Arbitrator's finding as to causal connection as to Petitioner's bilateral elbow conditions (including neuropathy and/or epicondylitis diagnosed in fall 2014).

Regarding the duration of TTD, the Commission finds Petitioner's testimony untrustworthy. Petitioner asserts that he was totally disabled until Dr. Rhode returned him to modified duty (at Petitioner's request) on August 10, 2016. However, the surveillance video evidence and Petitioner's own testimony indicate that he was physically capable of working -- and indeed, was being paid for working – well before then. Petitioner's quibbles regarding not being "on payroll" at his friend's business suggest strongly that he was being paid in cash, and the purportedly sporadic and insubstantial auto mechanic work he did in his home garage (for which he received "donations") are not availing. The Commission notes that, in his report from June 22, 2015, Section 12 examiner Dr. Weiss wrote that Petitioner related that he "has done some seasonal work" since losing his job with Respondent.

Petitioner's disability ceased being total certainly no later than June 9, 2016, the date that he was first captured on video doing work at Sparkie's Garage. The Commission acknowledges here that the video shows nothing to contradict Dr. Rhode's current diagnosis of left rotator cuff tendinopathy, and so does not find the video sufficient to dispute the medical treatment prescription.

Accordingly, the Commission modifies the Arbitrator's award of temporary total disability as discussed above and vacates the causation finding as to the condition of ill-being in Petitioner's elbows. The other findings of the Arbitrator are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 18, 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 $ 453.97 per week for 37 & 2/7 weeks, for: (i) the period commencing **August 21, 2014 through September 10, 2014**; and (ii) the period commencing **October 13, 2015 through June 8, 2016**, these being the periods of temporary total incapacity for work under § 8(b). Respondent shall be given credit against this amount for $13,489.38 paid prior to hearing as temporary total disability.

18IWCC0468

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's finding of causal connection between Petitioner's employment and the condition of ill-being in his elbows is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for the prospective left shoulder surgery as recommended by Dr. Blair Rhode.

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

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

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 set at $17,000. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 27 2018

o-06/05/18
jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

RICCO, CHRISTIAN J
Employee/Petitioner

Case# **14WC034216**

EBY-BROWN CO
Employer/Respondent

18IWCC0468

On 11/18/2016, 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 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
MICHAEL K BRANDOW
3100 N KNOXVILLE AVE
PEORIA, IL 61693

2284 COZZI & GOGGIN-WARD
LARRY COZZI
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555

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)

Christian J. Ricco
Employee/Petitioner

v.

EBY-Brown Co.
Employer/Respondent

Case # 14 WC 34216

Consolidated cases: n/a

18IWCC0468

An *Application for Adjustment 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 October 18, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0468

FINDINGS

On the date of accident/manifestation, August 15, 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 $35,409.40; the average weekly wage was $680.95.

On the date of accident, Petitioner was 36 years of age, married with 1 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 $13,489.38 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $13,489.38.

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

ORDER

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 11, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the left shoulder surgery recommended by Dr. Blair Rhode.

Respondent shall pay Petitioner temporary total disability benefits of $453.97 per week for 53 6/7 weeks commencing August 21, 2014, through September 10, 2014, and October 13, 2015, through September 11, 2016, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

November 17, 2016
Date

NOV 18 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 August 15, 2014. According to the Application, Petitioner sustained an injury "In course of employment" and sustained an injury to "both shoulders and elbows; man as a whole" (Petitioner's Exhibit 1). It was not clear from the Application whether this claim was repetitive trauma or a specific date of accident. However, the evidence clearly indicated that this was, in fact, a repetitive trauma claim. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. At trial, Petitioner and Respondent stipulated that Petitioner sustained a work-related accident; however, Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent between January, 2012, and August, 2014, as a truck driver. Petitioner's job duties consisted primarily of making deliveries of various items to convenience stores, gas stations, etc. When Petitioner made these deliveries, he pulled out a metal ramp from the truck, loaded the products on a dolly and moved the dolly into the store.

Petitioner testified that shortly before August 14, 2014, he began to experience pain in both of his shoulders and elbows. He reported this to Respondent and an Incident Report was prepared. In this report, Petitioner stated that over the past few months, he had noticed discomfort in his shoulders and elbows due to work duties. Petitioner also noted that on August 15, 2014, he felt a strain in his right shoulder while working (Petitioner's Exhibit 2).

Petitioner went to the ER of St. Mary's Hospital on August 20, 2014. At that time, Petitioner gave a history of bilateral shoulder and elbow pain worsening since August 15, 2014, and that he did heavy lifting at work. X-rays of the shoulders and elbows were taken which were negative for fractures. Petitioner was directed to contact the Occupational Health Department (Petitioner's Exhibit 8).

Petitioner was evaluated at the Occupational Health Department on August 20, 2014. At that time, most of Petitioner's complaints were in regard to the right shoulder. Petitioner was released to return to work, but with a five pound lifting restriction (Petitioner's Exhibit 8).

Petitioner was subsequently seen by Dr. Brent Johnson, an orthopedic surgeon, on September 8, 2014. Dr. Johnson opined that Petitioner had calcifying tendinitis of the right shoulder. He administered a steroid injection in the right shoulder (Petitioner's Exhibit 3).

On September 15, 2014, Petitioner had nerve conduction studies performed on both upper extremities. The studies were positive for mild median nerve entrapment on both the right and left sides (Petitioner's Exhibit 3).

Petitioner received physical therapy from September 22, 2014, through October 22, 2014, for his upper extremity symptoms (Petitioner's Exhibit 8). On October 20, 2014, an MRI was performed on Petitioner's right shoulder which revealed that Petitioner had tendinosis of the subscapularis and infraspinatus, but no rotator cuff or tendon retractions (Petitioner's Exhibit 4).

Petitioner was seen by Dr. John Mahoney, an orthopedic surgeon associated with Dr. Johnson, on November 4, 2014. At that time, most of Petitioner's complaints were in regard to both elbows. Dr. Mahoney opined that Petitioner had bilateral epicondylitis and recommended continued conservative treatment (Petitioner's Exhibit 3). When Dr. Mahoney saw Petitioner on December 8, 2014, he recommended deferring treatment on the elbows until his shoulders were treated (Petitioner's Exhibit 10).

Petitioner continued to be seen by Dr. Mahoney and Dr. Johnson from December, 2014, through March, 2015. In March, 2015, Dr. Johnson recommended that Petitioner have right shoulder surgery (Petitioner's Exhibit 10).

At the direction of Respondent, Petitioner was examined by Dr. Stephen Weiss, an orthopedic surgeon, on June 15, 2015. In connection with his examination of Petitioner, Dr. Weiss reviewed medical reports provided to him by Respondent. When evaluated by Dr. Weiss, Petitioner complained of bilateral elbow and shoulder symptoms; however, the most of severe complaints were in regard to the right shoulder. Dr. Weiss opined that Petitioner had right shoulder rotator cuff tendinosis with acromioclavicular arthritis which he opined was work-related. He also stated that right shoulder surgery was appropriate. In regard to the left shoulder, Dr. Weiss opined that a diagnosis was premature until an MRI was performed; however, he suspected rotator cuff tendinosis (Petitioner's Exhibit 10).

An MRI of the left shoulder was performed on May 23, 2015, which revealed a possible anterior supraspinatus tendon tear (Petitioner's Exhibit 5). Dr. Weiss did not make any reference to this diagnostic procedure in his report.

Petitioner was later seen by Dr. Blair Rhode, an orthopedic surgeon, on September 12, 2015. At that time, Petitioner complained of bilateral shoulder and elbow pain. Dr. Rhode examined Petitioner and reviewed the MRI of Petitioner's right shoulder. Dr. Rhode recommended that Petitioner have arthroscopic surgery on the right shoulder (Petitioner's Exhibit 6).

Dr. Rhode performed arthroscopic surgery on Petitioner's right shoulder on October 13, 2015. The procedure consisted of a subacromial decompression; synovectomy and acromioclavicular arthroplasty (Petitioner's Exhibit 7).

Following surgery, Petitioner continued to be treated by Dr. Rhode for both post-operative care for his right shoulder and for his continued left shoulder symptoms. On November 19, 2015, Dr. Rhode administered an injection to Petitioner's left shoulder and ordered physical therapy (Petitioner's Exhibit 6).

When Dr. Rhode saw Petitioner on January 17, 2016, he noted that Petitioner continued to have left shoulder symptoms. Dr. Rhode recommended Petitioner have arthroscopic surgery performed on the left shoulder (Petitioner's Exhibit 6).

On February 15, 2016, Respondent obtained a utilization review from Dr. Glenn Smith, an orthopedic surgeon. Dr. Smith opined that surgery was not appropriate at that time and further conservative treatment was indicated (Respondent's Exhibit 5).

Dr. Smith's opinion in regard to additional medical treatment was communicated to Dr. Rhode and Dr. Rhode ordered additional physical therapy. In his record of June 21, 2016, Dr. Rhode noted that Petitioner continued to have left shoulder symptoms and that the insurance had declined to authorize further physical therapy. When Dr. Rhode saw Petitioner on July 13, 2016, he renewed his recommendation that Petitioner have arthroscopic surgery on the left shoulder. Primarily because of Petitioner's financial situation, Dr. Rhode authorized Petitioner to return to work on modified medium duty (Petitioner's Exhibit 6).

Dr. Rhode was deposed on July 13, 2016, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner, Dr. Rhode's testimony was consistent with his medical records. Dr. Rhode opined that Petitioner's left shoulder condition was related to his work activity. In regard to treatment, Dr. Rhode stated that conservative measures had been exhausted and that the only alternatives were for Petitioner to either live with the symptoms or proceed with surgery (Petitioner's Exhibit 9; p 22).

Dr. Rhode again saw Petitioner on September 21, 2016. At that time, he renewed his recommendation that Petitioner have arthroscopic surgery on the left shoulder (Petitioner's Exhibit 6). At trial, Petitioner testified that he does want to proceed with the surgery as recommended by Dr. Rhode.

At trial, Petitioner testified that he requested Dr. Rhode release him to return to work because Respondent had terminated payment of temporary total disability benefits in February, 2016. Petitioner was able to find a job driving a truck for a company called "Tube's Trucking." Petitioner drives a truck that hauls grain, but he does not do any loading or unloading of the product. Petitioner stated that he started the job on September 12, 2016.

Petitioner also testified that he would periodically help out a friend, Patrick Gillen, at his garage in Knoxville, Illinois. Petitioner described the work as being minimal and did not engage in any heavy lifting or strenuous activities. Petitioner was not on the payroll, but he began helping out his friend sometime after August 10, 2016. Finally, Petitioner also stated that he did some mechanical work at his home, primarily minor auto repair such as oil changes, brake work, etc. Petitioner stated that he may have worked on one, or possibly two cars, per week.

Sean Dawson, a private investigator, testified on behalf of Respondent when this case was tried. Respondent tendered into evidence surveillance activity reports prepared by Dawson dated June 9, 2016, June 16, 2016, and June 30, 2016. The reports received into evidence were consistent with the surveillance video tendered into evidence and discussed herein (Respondent's Exhibits 7A, 8A and 9A). Respondent's Exhibit 9A was rejected and not received into evidence because of a hearsay objection made by Petitioner's counsel, which was sustained by the Arbitrator.

As noted above, Respondent also tendered into evidence surveillance video of the Petitioner obtained by Dawson on June 9, June 10, June 16 and June 17, 2016. The surveillance video was watched by the Arbitrator and counsel for the parties at trial. The Arbitrator also reviewed the video when preparing this Decision. The video was approximately 26 minutes long and it showed Petitioner driving a riding lawn mower, getting in and out of vehicles, walking around,

etc. The Petitioner was not observed performing any activities inconsistent with his claim that he was disabled.

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 August 15, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding his job activities and the gradual onset of symptoms to both shoulders and elbows was unrebutted.

Petitioner's treating physicians as well as Respondent's Section 12 examiner, Dr. Stephen Weiss, opined that Petitioner's bilateral shoulder and elbow conditions were work-related.

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

The Arbitrator concludes that all of the medical services provided to Petitioner were reasonable and necessary and 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 11, 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:

Subsequent to Dr. Rhode's recommendation that Petitioner undergo arthroscopic surgery on the left shoulder, Respondent obtained a utilization review from Dr. Smith who opined that further conservative treatment was appropriate.

When Dr. Rhode reviewed Dr. Smith's utilization review, he ordered additional physical therapy which Respondent then declined to authorize.

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

The Arbitrator concludes that Petitioner is entitled to prospective medical treatment including, but not limited to, the left shoulder arthroscopic surgery as recommended by Dr. Rhode.

In support of this conclusion the Arbitrator notes the following:

Subsequent to Dr. Smith's utilization review, Dr. Rhode ordered further physical therapy which Respondent declined to authorize.

Dr. Rhode testified that arthroscopic surgery on Petitioner's left shoulder was indicated because conservative measures had been exhausted.

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

The Arbitrator concludes that Petitioner is entitled to payment of temporary total disability benefits for 53 6/7 weeks, commencing August 21, 2014, through September 10, 2014, and October 13, 2015, through September 11, 2016.

In support of this conclusion the Arbitrator notes the following:

Petitioner was either authorized to be off work or only allowed to work on a limited basis by his treating physicians during the aforestated periods of time.

Petitioner did not return to regular employment until September 12, 2016.

There was nothing in the surveillance activity reports or surveillance video which revealed Petitioner performing any activities inconsistent with his claim that he was disabled.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Nunez,
Petitioner,

vs.

NO: 15 WC 06326

Imperial Marble Corp.,
Respondent.

18IWCC0469

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 31, 2017, is hereby affirmed and adopted.

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

DATED:

JUL 27 2018

o-07/25/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

NUNEZ, DANIEL
Employee/Petitioner

Case# 15WC006326

18IWCC0469

IMPERIAL MARBLE CORPORATION
Employer/Respondent

On 3/31/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1072 EPSTEIN, JACK R LAW OFFICES
4346 W 26TH ST
SUITE 2000
CHICAGO, IL 60623

0560 WIEDNER & McAULIFFE LTD
TIMOTHY S McNALLY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
) SS
COUNTY OF KANKAKEE)

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

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

Daniel Nunez
Employee/Petitioner
v.
Imperial Marble Corporation
Employer/Respondent

Case # 15 WC 6326

18IWCC0469

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **Kankakee**, on **July 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. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X Is Petitioner entitled to any prospective medical care?
L. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
M. X Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident **April 7, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,453.18**; the average weekly wage was **$566.41.**

On the date of accident, Petitioner was **43** years of age, **married** with **3** dependent children.

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

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

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

ORDER

Petitioner failed to prove he sustained accidental injuries in an accident on April 7, 2014, that arose out of and in the course of his employment with respondent.

Petitioner's claim is hereby denied and case is dismissed.

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

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

Christine Mowy

Signature of Arbitrator
IC ArbDec19(b)

03/09/2017
Date

MAR 31 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Nunez	)	
Petitioner,	)	
vs.	)	**No. 15 WC 6326**
Imperial Marble Corporation	)	
Respondent.	)	**18IWCC0469**
	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in Kankakee under the provisions of §19b/§8a on July 19, 2016. The parties agree that on April 7, 2014 petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that petitioner gave respondent notice of the accident within the time limits stated in the Act. They further agree petitioner earned $29,453.18 in the year pre-dating the accident and the petitioner's average weekly wage calculated pursuant to §10 was $566.41.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. Whether respondent is liable for the unpaid medical bills and for costs of prospective medical treatment.
4. Whether petitioner is due TTD.
5. Whether respondent is liable for penalties and attorneys' fees.

STATEMENT OF FACTS

The petitioner does not speak English; his native language is Spanish. He testified with the assistance of Theresa Malave, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Ms. Malave served as an interpreter for the petitioner.

Petitioner, Daniel Nunez Testimony

Petitioner testified he was employed by respondent since 2002. His original job was painting and spraying. Three or four years after starting his employment with respondent, petitioner went to the finishing department. The requirements of the job of finisher were sanding, spraying and finishing, which included sanding the edges [of the tops
]. As a finisher, petitioner was required to lift sinks, which may weigh up to 60 pounds.

On September 11, 2012, petitioner injured his back when he lifted a piece of granite over his head. He was sent to Rush Copley Health Care Center Occupational Medical Clinic. Petitioner was put on light duty; lifting no more than 20 pounds, no twisting and alternative sitting and

standing. He did inspections. He testified that not all the sanding jobs [of the tops he was examining] were not always done correctly.

Petitioner was later assigned to "side splashes". This was buffing small tablets and samples. Sometimes petitioner packed the small countertops, that weighted five to ten pounds. Petitioner also cut some long counter tops known as flat stacks. Petitioner used a staple gun to pack. The staple gun weighed between five and ten pounds.

Petitioner went to the doctor on April 16, 2014 with complaints of right shoulder pain. Petitioner told Danny, who is in charge of reporting injuries, of pain his right shoulder pain. Danny took petitioner to Rush Copley Health Care Center. Danny spoke English to the doctor at Rush Copley with petitioner present.

After that, petitioner slowly performed his job. Petitioner testified he was pressured to work fast and had meetings with Dionicio, Jose and Tiffany regarding his performance.

Petitioner continued to see the doctors at Rush Copley. Dr. Joyce, with Rush Copley, referred petitioner to Dr. John Pinnello and to physical therapy. Physical therapy was obtained outside of work hours.

Petitioner continued working until April 10, 2015 when he brought a note from his own doctor, Dr. Chandrasekhar Sompalli, who kept him off work. Dr. Sompalli advised petitioner he needs surgery.

After petitioner returned to work on light duty. post September 11, 2012 back injury, he would see Ricardo Diaz almost every day. Petitioner was aware of a camera pointed to the jobs he was working.

On cross examination petitioner testified his restrictions were only honored for two to three months after returning to work subsequent to his September 11, 2012 back injury. Thereafter, according to petitioner, he was forced to perform work that exceeded his restrictions. Petitioner testified that grinding exceeded his restrictions, which he performed eight hours a day. Petitioner testified he was also forced to sand; use the staple gun; cut flat stacks; remove garbage; work with foam packs and scrubbed floors. All of which exceeded his restrictions.

Petitioner testified he was moved around to perform various jobs which included grinding one day and inspecting countertops another. Petitioner testified the sanding job was the one he performed the most after he returned to work post September 11, 2012 accident.

Petitioner denied he was suspended. After being shown Respondent's Exhibit 1, petitioner agreed he was suspended for three days after he reportedly was caught three days in a row sanding; in violation of the quality control policy. Petitioner agreed he told Danny his shoulder was hurting only after he returned from his suspension. Petitioner agreed he was suspended for a day on December 3, 2014 when he was sanding. Petitioner did not recall if he had a performance review with Tiffany on May 1, 2014.

Petitioner testified he was told by Dionicio Zarate to perform the grinding, sanding, stapling, buffing, cutting flat stacks, foam packing and floor sweeping. Petitioner testified he signed Respondent's Exhibit 1 only because he was afraid he would be sent home if he didn't. Petitioner testified that the job of quality control inspector was to insure the countertops were smooth as they come off the line. This would mean wiping or buffing to make sure the tops were in proper condition.

At the time he saw Dr. Joyce petitioner told Dr. Joyce only of the buffing and no other jobs. Petitioner provided details of the other jobs he was doing when he first saw Dr. Sompalli.

Chad Cartwright Testimony

Chad Cartwright testified in behalf of respondent. He is employed by respondent as vice president of operations. He has been employed by respondent for five and a half years. He handles the day to day operations of production. As such, Cartwright is familiar with the job of quality control inspector. The job of quality control inspector is accurately depicted in Respondent's Exhibit 3. The inspector also has helpers available during the entire shift. Cartwright testified the job required no lifting.

Cartwright was aware petitioner was a finisher before he injured his back on September 11, 2012. The job as finisher required petitioner to buff and sand the tops. As inspector, the petitioner either passes the tops or rejects them. In order to get the work "put through", the inspector either has to pass or reject it and nothing more. To do anything other than that would stop production. If the inspector did anything else, it would subject the inspector to disciplinary action.

Cartwright had interactions with Dionicio and Ricardo Diaz on a daily basis. Cartwright was Diaz direct supervisor. Cartwright was not aware the petitioner's restrictions were not being honored by his supervisors.

Cartwright identified Respondent's Exhibit 4 as petitioner's May 1, 2014 performance appraisal which Cartwright did not believe was very good. Cartwright identified Respondent's Group Exhibit 5 as warnings to petitioner dated January 14, 2013, November 30, 2012, February 14, 2013 and September 20, 2013. Cartwright confirmed Donny Agler (not Danny) was the facility supervisor. According to Cartwright, an injury was to be reported to the employee's supervisor first.

Cartwright confirmed Ricardo Diaz is respondent's plant manager, Dionicio Zarate is in charge of finishing and Tiffany Viala is in charge of quality control.

(On the issue of a continuance of the hearing from Ottawa in June, 2016 to Kankakee, 2016 Cartwright testified that Ricardo Diaz had put in a two-week resignation notice but now continues to work for the company.) Diaz had the ability to direct petitioner to perform certain jobs.

Rush Copley Healthcare Center/Occupational Medicine Clinic Records (PX.1).

These records include treatment for petitioner's back injury of September 11, 2012. Treatment for petitioner's back injury began on September 15, 2012. According to the records, petitioner was last seen at Rush Copley for his back on October 15, 2012, at which time he was being referred to M& M Orthopaedics.

He was first seen at Rush Copley for right shoulder complaints on April 15, 2014. Petitioner reported a date of accident of April 7, 2014. According to the history, petitioner was polishing when he started to have pain in his right shoulder; worked for a few days, then had a few days off. The rest brought no improvement. He could not raise his arm overhead. On April 23, 2014, physical therapy was ordered. He was seen again on May 14, 2014 and May 28, 2014. On May 28, 2014, Dr. Joyce discussed the possibility of referring petitioner for an orthopedic evaluation.

M & M Orthopaedics Records (PX.2)

These records are for treatment of petitioner's back injury. These records confirm petitioner received his first seen by Dr. Dalip Pelinkovic on October 12, 2012 for his back problem. These records end with a visit of April 14, 2014. At the April 14, 2014 visit, petitioner was seen for the back condition only.

Open Advanced MRI October 12, 2012 Medical Bill (PX.3)

This is for treatment of petitioner's September 11, 2012 back injury only.

Naperville Surgical Centre Medical Bills (PX.4)

These are for bills from February 7, 2013 and November 7, 2013 for treatment of petitioner's back.

Future Diagnostic Group LLC Bills (PX.5)

The only pertinent bill to this claim is the $1,211.00 bill for the right shoulder MRI of June 27, 2014.

Atlas Physical Therapy & Sports Medicine Specialists Records & Bills (PX.6)

These records and bills include treatment and costs for both petitioner's lower back and claimed shoulder injury.

Castle Orthopaedics and Sports Medicine Records & Bills (PX. 7)

Petitioner was first seen by Dr. Pinnello on July 10, 2014 with right shoulder complaints. Petitioner related that on April 7, 2014 he injured his shoulder while polishing in a repetitive motion in a circular fashion. He reported continued pain despite receiving anti-inflammatories and physical therapy. Dr. Pinnello reviewed the MRI that accompanied petitioner which reportedly showed probable partial cuff tear as well as tendinosis. Dr. Pinnello recommended an injection.

Petitioner followed up with Dr. Pinnello on August 8, 2014 with ongoing complaints of pain. On September 25, 2014, petitioner had bilateral shoulder complaints. Dr. Pinnello questioned whether the left shoulder was related to work. He followed upon on October 2, 2014 with the same bilateral shoulder complaints. On November 3, 2014, petitioner advised Dr. Pinnello he was not going to claim his left shoulder problem as a worker-related condition. Petitioner was last seen by Dr. Pinnello on December 4, 2014. Dr. Pinnello recommended a repeat MRI as there may have been movement when the earlier one was done.

Illinois Orthopaedic Network Records & Bills (PX.8).

Petitioner was first seen by Dr. Chandrasekhar Sompalli on March 9, 2015 with history of inspecting and cleaning countertops with repetitive motion. Date of injury was reported as April 7, 2014. Dr. Sompalli reviewed the MRI and reported petitioner had a partial rotator cuff tear with bursitis, subacromial space and AC joint arthropathy. Dr. Sompalli recommended arthroscopic decompression surgery.

On April 11, 2015, Dr. Sompalli kept petitioner off work completely as petitioner complained the repetitive motion was making his arm worse. On May 30, 2015, Dr. Sompalli had the same recommendations. On August 24, 2015, Dr. Sompalli returned petitioner to light-duty work, lifting no more than 10 pounds, until surgery could be arranged.

January 28, 2016 Dr. Chandrasekhar Sompalli Evidence Deposition (PX.9).

Dr. Sompalli testified he first saw petitioner on March 9, 2015 with complaints of right shoulder pain for ten months (P.6). Dr. Sompalli examined both the left non-painful shoulder and the right painful shoulder (P.7). Dr. Sompalli diagnosed chronic right shoulder impingement syndrome and partial cuff tear based on the MRI (P.7). Dr. Sompalli testified the impingement

syndrome developed from repetitive activity of his shoulder either overhead or forced compression of it with the hand in a forced position (PP. 7-8)9). Dr. Sompalli recommended surgery for a subacromial decompression and possible cuff repair; he restricted petitioner to lifting no greater than 20 pounds. (P.10).

On April 11, 2015 petitioner reported to Dr. Sompalli that his shoulder was hurting due to the repetitive nature of his work; Dr. Sompalli kept petitioner completely off work. Dr. Sompalli understood petitioner was required to lift countertops up to 40 pounds, which was more than what the video showed (P.11). Petitioner advised Dr. Sompalli that his supervisors were making him do more work (P.11). Dr. Sompalli also believed the circular motion of petitioner, using his palms, can cause the impingement syndrome (P.12). Dr. Sompalli believed petitioner's work, as described by petitioner, was the cause of petitioner's right shoulder problem (PP.12-13).

Dr. Sompalli did not review the job video (P.22). Dr. Sompalli testified that petitioner had advised him the video did not accurately show petitioner's job. (P.22). Petitioner advised Dr. Sompalli that his supervisor was having him do a sanding job (P.24).

Dr. Sompalli believed the force needed to rub down a satin top would be less than a porous marble top (P.24). Dr. Sompalli could not remember if petitioner advised him whether he had assistants in lifting the sinks (P.25).

Employee Warning Notice Dated April 10, 2014 (RX.1)

Petitioner was given a written warning and a three-day suspension after he continued to go against the rules by sanding tops three days in a row.

Employee Warning Notice Dated December 3, 2014 (RX.2)

Petitioner was given a written warning after he was caught making a sanding block in the QC department. According to the notice, no sanding was to be done in the QC department; this is to be done only in the finishing department.

Video Tape of the Quality Control Inspector Job (RX.3)

The video showed an individual performing a job which Chad Cartwright testified was the job of quality control inspector. It showed an individual measuring, running hand over the surface, inspecting and wiping down the countertop. It did not show any sanding or buffing of the countertop. It also showed two helpers that moved the top after the individual completed the inspection.

Petitioner's Performance Appraisal Dated May 1, 2014 (RX.4)

Petitioner's overall performance appraisal rating was good. The only category petitioner was rated at below average was adherence to policy.

Employee Warning Notices (RX. Group 5)

According to these notices, which were dated November 30, 2012 through September 20, 2013, petitioner was written up for various infractions, including one dated September 20, 2013 when he was caught on camera taking another employee's stop sign sticker and when he was caught he rolled it up and threw it away. He received a three-day suspension for that infraction.

Dr. Nikhil N. Verma April 20, 2016 Evidence Deposition (RX.6)

Dr. Verma testified via deposition in behalf of respondent. Dr. Verma examined petitioner on behalf of respondent [on January 22, 2015] (P.8). Petitioner reported to Dr. Verma that his job required him to do frequent lifting, up to 40 pounds, in an eight-to-ten-hour day working from floor to overhead. Petitioner alleged his pain came on gradually over a couple of days. 9

Dr. Verma reviewed a job description and a video tape purportedly of the inspector job which showed an individual feeling, dusting/cleaning the countertops. There were also helpers present that moved the countertop in and out of position. All of this was done at waist level (P.10-11).

Dr. Verma examined the petitioner and reviewed X-rays taken at his office on the day of the exam, and also a July 1, 2014 MRI. Based upon his examination of the petitioner and review of the diagnostic studies, Dr. Verma concluded petitioner had a right shoulder impingement, possible partial rotator cuff tear and AC joint pain or arthrosis (P.12-13).

Dr. Verma did not see a relationship between petitioner's right shoulder condition and his work activities (P.13). Dr. Verma did not see any significant lifting or overhead activities that would be associated with this condition (P14). Although Dr. Verma believed petitioner may be a surgical candidate, he did not believe the need for the surgery was related to petitioner's work as a quality control inspector (P.14).

Dr. Verma believed the cause of petitioner's shoulder problems was the fact that petitioner merely fell within the general population who have normal degenerative process without any specific trauma or activities (P.15). Dr. Verma also believe petitioner could continue his job of quality control inspector without first having surgery (P.15).

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

The Arbitrator questions petitioner's credibility as he often times did not answer the questions asked, even when questioned by his own attorney. His testimony was not consistent with the histories he provided to the various treating and examining doctors. His credibility is also called into question when he denied he had been suspended and only agreed he had been suspended when confronted with respondent's exhibits confirming his suspensions.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator finds the following facts:

Petitioner failed to prove he injured his right shoulder in a repetitive work accident that arose out of and in the course of his employment with respondent on April 7, 2014, or at any time. Petitioner's testimony and medical history were inconsistent as to the work petitioner was required to perform as a quality control inspector. Petitioner had been a finisher until September 11, 2012 when he injured his back in a work-related accident. After that, he returned to work with restrictions and given the job of quality control inspector. According to the job description and the video, petitioner was not required to sand, grind or lift anything over 20 pounds. Petitioner's histories, as to the work he was doing that caused the right shoulder injury, is inconsistent with the job he was to have performed as a quality control inspector. Furthermore, petitioner provided a diverse history of what job he was performing when his right shoulder began to hurt.

He first advised Dr. Joyce at Rush Copley on April 15, 2014 that the pain in his right shoulder began when he was polishing, which is the similar history he gave to Dr. Pinnello on July 10, 2014. On March 9, 2015 he also advised Dr. Sompalli that he was cleaning countertops with repetitive motion when his shoulder began to hurt. However, Dr. Sompalli testified petitioner also told him that his supervisors were having him sand. Petitioner also told Dr. Verma that he had to lift up to forty pounds from floor to ceiling.

Although Dr. Sompalli testified petitioner's work caused the right arm problem, Dr. Sompalli relied upon miss-information provided by petitioner as to the actual job he was required to performs as a quality control inspector. Therefore, Dr. Sompalli's opinion on causation is without merit.

The credible evidence is that petitioner's job as a quality control inspector required him to inspect and wipe down countertops and did not require him to sand, lift or polish. The fact that petitioner claims his supervisors made him sand and grind is inconsistent with him being written up twice and suspended for sanding in violation of the quality control policy. Mr. Cartwright confirmed that petitioner, as an inspector, should not be stopping to sand and grind the defective product as it would slow down production. The job of quality control inspector was to inspect, wipe down, put a label on it and moved it on.

The Arbitrator also questions the fact that petitioner was seen by an orthopedic surgeon at M & M Orthopaedics for his back on April 14, 2014, and made no mention of problems with his right arm. Furthermore, petitioner did not claim a problem with his right arm until he returned from a three-day suspension.

The Arbitrator further notes petitioner began complaining of problems with his left arm as of his September 25, 2014 visit with Dr. Pinnello. There was no attributable cause to petitioner's left arm problem. Petitioner's left arm problem, which began without a known cause, gives credence to Dr. Verma's opinion that the cause of petitioner's right shoulder condition was merely from the fact that petitioner fell into the general population who suffered normal degenerative process.

For the aforementioned reasons, the Arbitrator finds petitioner failed to prove he sustained injuries to his right shoulder from an accident that arose out of and in the course of his employment with respondent on April 7, 2014 and denies his claim.

As the Arbitrator determined petitioner failed to prove that an accident occurred which arose out of and in the course of petitioner's employment with respondent on April 7, 2014, all other issues, including the issue of penalties and attorneys' fees, are moot.

mak-6/18/18 (from MP spreadsheet)

INTEREST CALCULATION
SISF
FY 2017

	Jul-16 Interest	Aug-16 Interest	Sep-16 Interest	Oct-16 Interest	Nov-16 Interest	Dec-16 Interest	Totals
Assess	$ 2,494.86	$ 2,914.71	$ 3,110.50	$ 3,497.58	$ 3,278.02	$ 3,653.52	$ 18,949.19
All	$ 8,719.00	$ 10,230.00	$ 10,946.00	$ 12,321.00	$ 11,555.00	$ 12,910.00	$ 66,681.00

	Jan-17 Interest	Feb-17 Interest	Mar-17 Interest	Apr-17 Interest	May-17 Interest	Jun-17 Interest	
Assess	$ 4,012.16	$ 3,995.06	$ 4,716.07	$ 4,954.80	$ 5,169.60	$ 5,537.93	$ 28,385.63
All	$ 14,214.00	$ 14,195.00	$ 16,879.00	$ 17,445.00	$ 18,212.00	$ 19,542.00	$ 100,487.00

Assessments	$ 47,334.82
	$ 167,168.00
Companies	$ 119,833.18

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Nunez,
Petitioner,

vs.

NO: 15 WC 06326

Imperial Marble Corp.,
Respondent.

18IWCC0469

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 31, 2017, is hereby affirmed and adopted.

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

DATED:

JUL 27 2018

o-07/25/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

NUNEZ, DANIEL
Employee/Petitioner

Case# **15WC006326**

18IWCC0469

IMPERIAL MARBLE CORPORATION
Employer/Respondent

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

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4346 W 26TH ST
SUITE 2000
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ONE N FRANKLIN ST SUITE 1900
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STATE OF ILLINOIS)
) SS
COUNTY OF KANKAKEE)

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

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

Daniel Nunez
Employee/Petitioner
v.
Imperial Marble Corporation
Employer/Respondent

Case # 15 WC 6326

18IWCC0469

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **Kankakee**, on **July 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. 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?
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J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X Is Petitioner entitled to any prospective medical care?
L. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
M. X Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident **April 7, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,453.18**; the average weekly wage was **$566.41.**

On the date of accident, Petitioner was **43** years of age, **married** with **3** dependent children.

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

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

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

ORDER

Petitioner failed to prove he sustained accidental injuries in an accident on April 7, 2014, that arose out of and in the course of his employment with respondent.

Petitioner's claim is hereby denied and case is dismissed.

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

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

Christine Moy

Signature of Arbitrator
IC ArbDec19(b)

03/09/2017
Date

MAR 31 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Nunez	)	
Petitioner,	)	
vs.	)	**No. 15 WC 6326**
Imperial Marble Corporation	)	**18IWCC0469**
Respondent.	)	
	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in Kankakee under the provisions of §19b/§8a on July 19, 2016. The parties agree that on April 7, 2014 petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that petitioner gave respondent notice of the accident within the time limits stated in the Act. They further agree petitioner earned $29,453.18 in the year pre-dating the accident and the petitioner's average weekly wage calculated pursuant to §10 was $566.41.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. Whether respondent is liable for the unpaid medical bills and for costs of prospective medical treatment.
4. Whether petitioner is due TTD.
5. Whether respondent is liable for penalties and attorneys' fees.

STATEMENT OF FACTS

The petitioner does not speak English; his native language is Spanish. He testified with the assistance of Theresa Malave, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Ms. Malave served as an interpreter for the petitioner.

Petitioner, Daniel Nunez Testimony

Petitioner testified he was employed by respondent since 2002. His original job was painting and spraying. Three or four years after starting his employment with respondent, petitioner went to the finishing department. The requirements of the job of finisher were sanding, spraying and finishing, which included sanding the edges [of the tops
]. As a finisher, petitioner was required to lift sinks, which may weigh up to 60 pounds.

On September 11, 2012, petitioner injured his back when he lifted a piece of granite over his head. He was sent to Rush Copley Health Care Center Occupational Medical Clinic. Petitioner was put on light duty; lifting no more than 20 pounds, no twisting and alternative sitting and

standing. He did inspections. He testified that not all the sanding jobs [of the tops he was examining] were not always done correctly.

Petitioner was later assigned to "side splashes". This was buffing small tablets and samples. Sometimes petitioner packed the small countertops, that weighted five to ten pounds. Petitioner also cut some long counter tops known as flat stacks. Petitioner used a staple gun to pack. The staple gun weighed between five and ten pounds.

Petitioner went to the doctor on April 16, 2014 with complaints of right shoulder pain. Petitioner told Danny, who is in charge of reporting injuries, of pain his right shoulder pain. Danny took petitioner to Rush Copley Health Care Center. Danny spoke English to the doctor at Rush Copley with petitioner present.

After that, petitioner slowly performed his job. Petitioner testified he was pressured to work fast and had meetings with Dionicio, Jose and Tiffany regarding his performance.

Petitioner continued to see the doctors at Rush Copley. Dr. Joyce, with Rush Copley, referred petitioner to Dr. John Pinnello and to physical therapy. Physical therapy was obtained outside of work hours.

Petitioner continued working until April 10, 2015 when he brought a note from his own doctor, Dr. Chandrasekhar Sompalli, who kept him off work. Dr. Sompalli advised petitioner he needs surgery.

After petitioner returned to work on light duty. post September 11, 2012 back injury, he would see Ricardo Diaz almost every day. Petitioner was aware of a camera pointed to the jobs he was working.

On cross examination petitioner testified his restrictions were only honored for two to three months after returning to work subsequent to his September 11, 2012 back injury. Thereafter, according to petitioner, he was forced to perform work that exceeded his restrictions. Petitioner testified that grinding exceeded his restrictions, which he performed eight hours a day. Petitioner testified he was also forced to sand; use the staple gun; cut flat stacks; remove garbage; work with foam packs and scrubbed floors. All of which exceeded his restrictions.

Petitioner testified he was moved around to perform various jobs which included grinding one day and inspecting countertops another. Petitioner testified the sanding job was the one he performed the most after he returned to work post September 11, 2012 accident.

Petitioner denied he was suspended. After being shown Respondent's Exhibit 1, petitioner agreed he was suspended for three days after he reportedly was caught three days in a row sanding; in violation of the quality control policy. Petitioner agreed he told Danny his shoulder was hurting only after he returned from his suspension. Petitioner agreed he was suspended for a day on December 3, 2014 when he was sanding. Petitioner did not recall if he had a performance review with Tiffany on May 1, 2014.

Petitioner testified he was told by Dionicio Zarate to perform the grinding, sanding, stapling, buffing, cutting flat stacks, foam packing and floor sweeping. Petitioner testified he signed Respondent's Exhibit 1 only because he was afraid he would be sent home if he didn't. Petitioner testified that the job of quality control inspector was to insure the countertops were smooth as they come off the line. This would mean wiping or buffing to make sure the tops were in proper condition.

At the time he saw Dr. Joyce petitioner told Dr. Joyce only of the buffing and no other jobs. Petitioner provided details of the other jobs he was doing when he first saw Dr. Sompalli.

Chad Cartwright Testimony

Chad Cartwright testified in behalf of respondent. He is employed by respondent as vice president of operations. He has been employed by respondent for five and a half years. He handles the day to day operations of production. As such, Cartwright is familiar with the job of quality control inspector. The job of quality control inspector is accurately depicted in Respondent's Exhibit 3. The inspector also has helpers available during the entire shift. Cartwright testified the job required no lifting.

Cartwright was aware petitioner was a finisher before he injured his back on September 11, 2012. The job as finisher required petitioner to buff and sand the tops. As inspector, the petitioner either passes the tops or rejects them. In order to get the work "put through", the inspector either has to pass or reject it and nothing more. To do anything other than that would stop production. If the inspector did anything else, it would subject the inspector to disciplinary action.

Cartwright had interactions with Dionicio and Ricardo Diaz on a daily basis. Cartwright was Diaz direct supervisor. Cartwright was not aware the petitioner's restrictions were not being honored by his supervisors.

Cartwright identified Respondent's Exhibit 4 as petitioner's May 1, 2014 performance appraisal which Cartwright did not believe was very good. Cartwright identified Respondent's Group Exhibit 5 as warnings to petitioner dated January 14, 2013, November 30, 2012, February 14, 2013 and September 20, 2013. Cartwright confirmed Donny Agler (not Danny) was the facility supervisor. According to Cartwright, an injury was to be reported to the employee's supervisor first.

Cartwright confirmed Ricardo Diaz is respondent's plant manager, Dionicio Zarate is in charge of finishing and Tiffany Viala is in charge of quality control.

(On the issue of a continuance of the hearing from Ottawa in June, 2016 to Kankakee, 2016 Cartwright testified that Ricardo Diaz had put in a two-week resignation notice but now continues to work for the company.) Diaz had the ability to direct petitioner to perform certain jobs.

Rush Copley Healthcare Center/Occupational Medicine Clinic Records (PX.1).

These records include treatment for petitioner's back injury of September 11, 2012. Treatment for petitioner's back injury began on September 15, 2012. According to the records, petitioner was last seen at Rush Copley for his back on October 15, 2012, at which time he was being referred to M& M Orthopaedics.

He was first seen at Rush Copley for right shoulder complaints on April 15, 2014. Petitioner reported a date of accident of April 7, 2014. According to the history, petitioner was polishing when he started to have pain in his right shoulder; worked for a few days, then had a few days off. The rest brought no improvement. He could not raise his arm overhead. On April 23, 2014, physical therapy was ordered. He was seen again on May 14, 2014 and May 28, 2014. On May 28, 2014, Dr. Joyce discussed the possibility of referring petitioner for an orthopedic evaluation.

M & M Orthopaedics Records (PX.2)

These records are for treatment of petitioner's back injury. These records confirm petitioner received his first seen by Dr. Dalip Pelinkovic on October 12, 2012 for his back problem. These records end with a visit of April 14, 2014. At the April 14, 2014 visit, petitioner was seen for the back condition only.

Open Advanced MRI October 12, 2012 Medical Bill (PX.3)

This is for treatment of petitioner's September 11, 2012 back injury only.

Naperville Surgical Centre Medical Bills (PX.4)

These are for bills from February 7, 2013 and November 7, 2013 for treatment of petitioner's back.

Future Diagnostic Group LLC Bills (PX.5)

The only pertinent bill to this claim is the $1,211.00 bill for the right shoulder MRI of June 27, 2014.

Atlas Physical Therapy & Sports Medicine Specialists Records & Bills (PX.6)

These records and bills include treatment and costs for both petitioner's lower back and claimed shoulder injury.

Castle Orthopaedics and Sports Medicine Records & Bills (PX. 7)

Petitioner was first seen by Dr. Pinnello on July 10, 2014 with right shoulder complaints. Petitioner related that on April 7, 2014 he injured his shoulder while polishing in a repetitive motion in a circular fashion. He reported continued pain despite receiving anti-inflammatories and physical therapy. Dr. Pinnello reviewed the MRI that accompanied petitioner which reportedly showed probable partial cuff tear as well as tendinosis. Dr. Pinnello recommended an injection.

Petitioner followed up with Dr. Pinnello on August 8, 2014 with ongoing complaints of pain. On September 25, 2014, petitioner had bilateral shoulder complaints. Dr. Pinnello questioned whether the left shoulder was related to work. He followed upon on October 2, 2014 with the same bilateral shoulder complaints. On November 3, 2014, petitioner advised Dr. Pinnello he was not going to claim his left shoulder problem as a worker-related condition. Petitioner was last seen by Dr. Pinnello on December 4, 2014. Dr. Pinnello recommended a repeat MRI as there may have been movement when the earlier one was done.

Illinois Orthopaedic Network Records & Bills (PX.8).

Petitioner was first seen by Dr. Chandrasekhar Sompalli on March 9, 2015 with history of inspecting and cleaning countertops with repetitive motion. Date of injury was reported as April 7, 2014. Dr. Sompalli reviewed the MRI and reported petitioner had a partial rotator cuff tear with bursitis, subacromial space and AC joint arthropathy. Dr. Sompalli recommended arthroscopic decompression surgery.

On April 11, 2015, Dr. Sompalli kept petitioner off work completely as petitioner complained the repetitive motion was making his arm worse. On May 30, 2015, Dr. Sompalli had the same recommendations. On August 24, 2015, Dr. Sompalli returned petitioner to light-duty work, lifting no more than 10 pounds, until surgery could be arranged.

January 28, 2016 Dr. Chandrasekhar Sompalli Evidence Deposition (PX.9).

Dr. Sompalli testified he first saw petitioner on March 9, 2015 with complaints of right shoulder pain for ten months (P.6). Dr. Sompalli examined both the left non-painful shoulder and the right painful shoulder (P.7). Dr. Sompalli diagnosed chronic right shoulder impingement syndrome and partial cuff tear based on the MRI (P.7). Dr. Sompalli testified the impingement

syndrome developed from repetitive activity of his shoulder either overhead or forced compression of it with the hand in a forced position (PP. 7-8)9). Dr. Sompalli recommended surgery for a subacromial decompression and possible cuff repair; he restricted petitioner to lifting no greater than 20 pounds. (P.10).

On April 11, 2015 petitioner reported to Dr. Sompalli that his shoulder was hurting due to the repetitive nature of his work; Dr. Sompalli kept petitioner completely off work. Dr. Sompalli understood petitioner was required to lift countertops up to 40 pounds, which was more than what the video showed (P.11). Petitioner advised Dr. Sompalli that his supervisors were making him do more work (P.11). Dr. Sompalli also believed the circular motion of petitioner, using his palms, can cause the impingement syndrome (P.12). Dr. Sompalli believed petitioner's work, as described by petitioner, was the cause of petitioner's right shoulder problem (PP.12-13).

Dr. Sompalli did not review the job video (P.22). Dr. Sompalli testified that petitioner had advised him the video did not accurately show petitioner's job. (P.22). Petitioner advised Dr. Sompalli that his supervisor was having him do a sanding job (P.24).

Dr. Sompalli believed the force needed to rub down a satin top would be less than a porous marble top (P.24). Dr. Sompalli could not remember if petitioner advised him whether he had assistants in lifting the sinks (P.25).

Employee Warning Notice Dated April 10, 2014 (RX.1)

Petitioner was given a written warning and a three-day suspension after he continued to go against the rules by sanding tops three days in a row.

Employee Warning Notice Dated December 3, 2014 (RX.2)

Petitioner was given a written warning after he was caught making a sanding block in the QC department. According to the notice, no sanding was to be done in the QC department; this is to be done only in the finishing department.

Video Tape of the Quality Control Inspector Job (RX.3)

The video showed an individual performing a job which Chad Cartwright testified was the job of quality control inspector. It showed an individual measuring, running hand over the surface, inspecting and wiping down the countertop. It did not show any sanding or buffing of the countertop. It also showed two helpers that moved the top after the individual completed the inspection.

Petitioner's Performance Appraisal Dated May 1, 2014 (RX.4)

Petitioner's overall performance appraisal rating was good. The only category petitioner was rated at below average was adherence to policy.

Employee Warning Notices (RX. Group 5)

According to these notices, which were dated November 30, 2012 through September 20, 2013, petitioner was written up for various infractions, including one dated September 20, 2013 when he was caught on camera taking another employee's stop sign sticker and when he was caught he rolled it up and threw it away. He received a three-day suspension for that infraction.

Dr. Nikhil N. Verma April 20, 2016 Evidence Deposition (RX.6)

Dr. Verma testified via deposition in behalf of respondent. Dr. Verma examined petitioner on behalf of respondent [on January 22, 2015] (P.8). Petitioner reported to Dr. Verma that his job required him to do frequent lifting, up to 40 pounds, in an eight-to-ten-hour day working from floor to overhead. Petitioner alleged his pain came on gradually over a couple of days. 9

Dr. Verma reviewed a job description and a video tape purportedly of the inspector job which showed an individual feeling, dusting/cleaning the countertops. There were also helpers present that moved the countertop in and out of position. All of this was done at waist level (P.10-11).

Dr. Verma examined the petitioner and reviewed X-rays taken at his office on the day of the exam, and also a July 1, 2014 MRI. Based upon his examination of the petitioner and review of the diagnostic studies, Dr. Verma concluded petitioner had a right shoulder impingement, possible partial rotator cuff tear and AC joint pain or arthrosis (P.12-13).

Dr. Verma did not see a relationship between petitioner's right shoulder condition and his work activities (P.13). Dr. Verma did not see any significant lifting or overhead activities that would be associated with this condition (P14). Although Dr. Verma believed petitioner may be a surgical candidate, he did not believe the need for the surgery was related to petitioner's work as a quality control inspector (P.14).

Dr. Verma believed the cause of petitioner's shoulder problems was the fact that petitioner merely fell within the general population who have normal degenerative process without any specific trauma or activities (P.15). Dr. Verma also believe petitioner could continue his job of quality control inspector without first having surgery (P.15).

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

The Arbitrator questions petitioner's credibility as he often times did not answer the questions asked, even when questioned by his own attorney. His testimony was not consistent with the histories he provided to the various treating and examining doctors. His credibility is also called into question when he denied he had been suspended and only agreed he had been suspended when confronted with respondent's exhibits confirming his suspensions.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator finds the following facts:

Petitioner failed to prove he injured his right shoulder in a repetitive work accident that arose out of and in the course of his employment with respondent on April 7, 2014, or at any time. Petitioner's testimony and medical history were inconsistent as to the work petitioner was required to perform as a quality control inspector. Petitioner had been a finisher until September 11, 2012 when he injured his back in a work-related accident. After that, he returned to work with restrictions and given the job of quality control inspector. According to the job description and the video, petitioner was not required to sand, grind or lift anything over 20 pounds. Petitioner's histories, as to the work he was doing that caused the right shoulder injury, is inconsistent with the job he was to have performed as a quality control inspector. Furthermore, petitioner provided a diverse history of what job he was performing when his right shoulder began to hurt.

He first advised Dr. Joyce at Rush Copley on April 15, 2014 that the pain in his right shoulder began when he was polishing, which is the similar history he gave to Dr. Pinnello on July 10, 2014. On March 9, 2015 he also advised Dr. Sompalli that he was cleaning countertops with repetitive motion when his shoulder began to hurt. However, Dr. Sompalli testified petitioner also told him that his supervisors were having him sand. Petitioner also told Dr. Verma that he had to lift up to forty pounds from floor to ceiling.

Although Dr. Sompalli testified petitioner's work caused the right arm problem, Dr. Sompalli relied upon miss-information provided by petitioner as to the actual job he was required to performs as a quality control inspector. Therefore, Dr. Sompalli's opinion on causation is without merit.

The credible evidence is that petitioner's job as a quality control inspector required him to inspect and wipe down countertops and did not require him to sand, lift or polish. The fact that petitioner claims his supervisors made him sand and grind is inconsistent with him being written up twice and suspended for sanding in violation of the quality control policy. Mr. Cartwright confirmed that petitioner, as an inspector, should not be stopping to sand and grind the defective product as it would slow down production. The job of quality control inspector was to inspect, wipe down, put a label on it and moved it on.

The Arbitrator also questions the fact that petitioner was seen by an orthopedic surgeon at M & M Orthopaedics for his back on April 14, 2014, and made no mention of problems with his right arm. Furthermore, petitioner did not claim a problem with his right arm until he returned from a three-day suspension.

The Arbitrator further notes petitioner began complaining of problems with his left arm as of his September 25, 2014 visit with Dr. Pinnello. There was no attributable cause to petitioner's left arm problem. Petitioner's left arm problem, which began without a known cause, gives credence to Dr. Verma's opinion that the cause of petitioner's right shoulder condition was merely from the fact that petitioner fell into the general population who suffered normal degenerative process.

For the aforementioned reasons, the Arbitrator finds petitioner failed to prove he sustained injuries to his right shoulder from an accident that arose out of and in the course of his employment with respondent on April 7, 2014 and denies his claim.

As the Arbitrator determined petitioner failed to prove that an accident occurred which arose out of and in the course of petitioner's employment with respondent on April 7, 2014, all other issues, including the issue of penalties and attorneys' fees, are moot.

mak-6/18/18 (from MP spreadsheet)

INTEREST CALCULATION
SISF
FY 2017

	Jul-16 Interest	Aug-16 Interest	Sep-16 Interest	Oct-16 Interest	Nov-16 Interest	Dec-16 Interest	Totals
Assess	$ 2,494.86	$ 2,914.71	$ 3,110.50	$ 3,497.58	$ 3,278.02	$ 3,653.52	$ 18,949.19
All	$ 8,719.00	$ 10,230.00	$ 10,946.00	$ 12,321.00	$ 11,555.00	$ 12,910.00	$ 66,681.00

	Jan-17 Interest	Feb-17 Interest	Mar-17 Interest	Apr-17 Interest	May-17 Interest	Jun-17 Interest	
Assess	$ 4,012.16	$ 3,995.06	$ 4,716.07	$ 4,954.80	$ 5,169.60	$ 5,537.93	$ 28,385.63
All	$ 14,214.00	$ 14,195.00	$ 16,879.00	$ 17,445.00	$ 18,212.00	$ 19,542.00	$ 100,487.00

Assessments	$ 47,334.82
	$ 167,168.00
Companies	$ 119,833.18

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

Germenie Ward,
Petitioner,

vs.

NO: 14 WC 30834

TRI Industries,
Respondent.

18IWCC0470

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, 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, 2017 is hereby affirmed and adopted.

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

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

18IWCC0470

The party commencing 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:

JUL 27 2018

o-07/25/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WARD, GERMENIE
Employee/Petitioner

Case# **14WC030834**

13WC017920

TRI INDUSTRIES
Employer/Respondent

18IWCC0470

On 3/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0507 RUSIN & MACIOROWSKI LTD
JIGAR S DESAI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Germenie Ward
Employee/Petitioner

v.

TRI Industries
Employer/Respondent

Case # 14 WC 030834

Consolidated cases: 13WC 017920

18IWCC0470

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **February 7, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On August 27, 2014, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 $10,225.28; the average weekly wage was $196.64.

On the date of accident, Petitioner was 41 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 any amounts paid in medical bills through its group medical plan pursuant to Section 8(j) 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.

ORDER

Claim for compensation is denied, Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on August 27, 2014. August 27, 2017.

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

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

3/22/2017
Date

MAR 23 2017

INTRODUCTION

This matter was tried with a consolidated case No. 14WC030834 which involves a different date of loss. The decision in 14WC030834 is being entered concurrently with this Decision. These matters proceeded to hearing before Arbitrator Frank Soto and the disputed issues were:

14 WC 030834 (DOI 8/27/2014): *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 injury?; *J:* Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; *K.* Whether or not TTD benefits are owed? *L:*What is the nature and extent of the injury? *N:* Is Respondent due any credit?

13 WC 17920 (DOI 5/20/2013): *C:* Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?, *F:* Is Petitioner's current condition of ill-being causally related to the injury?, *J:* Were the medical services that were provided to Petitioner reasonable and necessary?, Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; *K:* Whether or not TTD benefits are owed; *L:*What is the nature and extent of the injury?; *N:* Is Respondent due any credit?

FINDINGS OF FACT

Petitioner filed two claims before the Illinois Workers' compensation commission. The first claim (13WC017920) filed on May 31, 2013 alleges an injury to the left shoulder and an accident date of May 20, 2013. Petitioner amended the initial claim Application, on July 1, 2013, to include the neck. On September 15, 2014, Petitioner filed another claim (14WC030834) alleging bilateral carpal tunnel syndrome and an accident date of July 1, 2014. On February 7, 2016, at the hearing, Petitioner made an oral motion to amend the date of accident to August 27, 2014 in case No. 14WC030834 without objection. The oral motion was granted and the accident was amended to August 27, 2014.

Petitioner testified he worked for Respondent, Tri Industries, on a part-time basis as a packager of printer cartridges. Petitioner began working for Respondent in July of 2012. Petitioner did not work for Respondent after May 20, 2013. Petitioner worked three days a week for approximately 18-20 hours per week. (T. 33-34) Respondent is a nonprofit organization whose mission is to provide people with disabilities job opportunities and enhance their skills so they can find work in the community. (T.97) When Petitioner was hired by Respondent, he was actively treating for PTSD, PSD and depression at Heartland Health Center. (PX 2)

Petitioner testified his normal work duties involve taking printer cartridges and refurbishing them. This involves making boxes, cleaning the cartridges, putting new labels on the cartridges, wiping the cartridges, and repackaging them. (T. 28-31). He testified the cartridges can weight anywhere between 2-20 pounds. He testified that he would work with 60-100 cartridges per day. He testified his work involves constant forceful gripping for approximately 90% of the day. (T. 32)

Petitioner testified he did not seek any treatment for carpal tunnel syndrome until May of 2014, approximately 1 year after he stopped working for Respondent. He testified he was eventually diagnosed with carpal tunnel syndrome but decided not to pursue treatment. (T. 45-48)

Petitioner testified he did not experience numbness or tingling in his hands or wrists before May 20, 2013 and he did not work for Respondent after May 20, 2013. (T. 58)

Petitioner began experiencing numbness and tingling in his hands until 2014. Petitioner had an EMG on July 1, 2014 which demonstrated evidence of bilateral carpal tunnel syndrome. Petitioner was referred to Dr. Forman from Illinois Bone & Joint Institute for carpal tunnel syndrome. Petitioner elected not to have surgery. In his letter dated May 12, 2015, Dr. Forman provided opinions regarding causal connection. Dr. Forman opined he could not determine whether Petitioner's job duties with Respondent caused, aggravated or exacerbated the carpal tunnel syndrome because Petitioner did not have any complaints prior to 2014. Dr. Forman further opined that he could not determine whether Petitioner's cervical neck condition masked or concealed Petitioner's carpal tunnel syndrome. (RX 5)

Dr. Zoellick, who performed a Section 12 exam for Respondent testified there was no causal connection between Petitioner's job duties and his carpal tunnel syndrome. (RX 6)

Petitioner testified he still wears wrist splints daily and he still experiences tingling in his arms and hands sometimes but he is fine when he takes medication. Petitioner's hands bother him if he is lifting over 20 pounds or stirring or working with his hands too much. (T.49, 51)

The Arbitrator incorporates the other findings of fact and conclusions of law from 13 WC 17920, particularly with respect to Petitioner's credibility.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (*O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980)) including that the accidental injury both arose out of and occurred in the course of his employment (*Horath v. Industrial Commission*, 96 Ill 2d 349 (1983)) and that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc Co. v. Industrial Board*, 284 Ill. 378 (1918). To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 205 (2003). Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e).

The Arbitrator finds the testimony of Petitioner not to be credible.

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT AND, WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Baggett v. Industrial Comm'n*, 201 Ill.2d. 187, 266 Ill.Dec. 836, 775 N.E.2d 908 (2002). The "arising out of" component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). The 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, 227 N.E.2d 65 (1967). In cases relying on the repetitive trauma concept, the Petitioner generally relies on the medical testimony to establish a causal connection between the claimant's work and the claimed disability. *See Peoria County Bellwood*, 115 Ill.2d 524 (1978).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has not proven by a preponderance of the credible evidence that Petitioner had an accident that arose out of and in the course of his employment by Respondent on August 27, 2014 as set forth more fully below.

Petitioner did not proffer any expert medical testimony showing Petitioner's work duties with Respondent caused, contributed or exacerbated his carpal tunnel syndrome. In cases relying on the repetitive trauma concept claimants generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed disability. *See Quaker Oats Co. v. Industrial Commission*, 414 Ill. 326 (1953). When the question is one specifically within the purview of experts, expert medical testimony is mandatory to show the claimant's work activities caused the condition of which the employee complaints. *Nunn V. Industrial Commission*, 157 Ill.App.3d 470 (4th Dist. 1987) *citing Westinghouse Electric Co. v. Industrial Commission*, 64 Ill.2d. 257 (1976).

Petitioner did not submit into evidence the causal opinion of his treating physician, Dr. Forman. Responded submitted the medical records of Dr. Forman into evidence. Dr. Forman opined he could not determine whether Petitioner's job duties with Respondent caused, aggravated or exacerbated the carpal tunnel syndrome because Petitioner did not have any complaints prior to 2014. Dr. Forman further opined that he could not determine whether Petitioner's cervical neck condition masked or concealed Petitioner's carpal tunnel syndrome. (RX 5) Responded submitted the evidence deposition of Dr. Zoellick, who performed an examination of Petitioner pursuant to Section 12. Dr. Zoellick testified Petitioner's carpal tunnel syndrome was not connected to his work duties with Respondent. (RX 6)

WITH RESPECT TO ISSUES (E), (J), (K),(L) and (N), THE ARBITRATOR FINDS AS FOLLOWS:

In light of the determination that Petitioner failed to establish his condition was casually connected to the injury arising out of and in the course of his employment with Respondent on August 27, 2014, the remaining issues of Respondent's liability including are moot and not reached by this Arbitrator.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Germenie Ward,
Petitioner,

vs.

NO: 13 WC 17920,

18IWCC0471

TRI Industries,
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, 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, 2017 is hereby affirmed and adopted.

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

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

18IWCC0471

The party commencing 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:

Joshua D. Luskin

JUL 27 2018
o-07/25/18
jdl/wj
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WARD, GERMENIE
Employee/Petitioner

Case# **13WC017920**

14WC030834

TRI INDUSTRIES
Employer/Respondent

18IWCC0471

On 3/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0507 RUSIN & MACIOROWSKI LTD
JIGAR S DESAI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Germenie Ward
Employee/Petitioner

v.

TRI Industries
Employer/Respondent

Case # 13 WC 017920

Consolidated cases: 14WC030834

18IWCC0471

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **February 7, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 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 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 **$10,225.28**; the average weekly wage was **$196.64**.

On the date of accident, Petitioner was **41** 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 **$3,511.43** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,127.62** for other benefits, for a total credit of **$4,639.05**.

Respondent is entitled to a credit of any amounts paid in medical bills through its group medical plan pursuant to Section 8(j) 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.

ORDER

Claim for compensation is denied, Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on May 20, 2013.

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

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

3/22/2017
Date

MAR 23 2017

INTRODUCTION

This matter was tried with a consolidated case No. 14WC030834 which involves a different date of loss. The decision in 14WC030834 is being entered concurrently with this Decision. These matters proceeded to hearing before Arbitrator Frank Soto and the disputed issues were:

13 WC 17920 (DOI 5/20/2013): *C:* Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?, *F:* Is Petitioner's current condition of ill-being causally related to the injury?, *J:* Were the medical services that were provided to Petitioner reasonable and necessary?, Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; *K:* Whether or not TTD benefits are owed; *L:*What is the nature and extent of the injury?; *N:* Is Respondent due any credit?

14 WC 030834 (DOI 8/27/2014): *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 injury?; *J:* Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; *K.* Whether or not TTD benefits are owed? *L:*What is the nature and extent of the injury? *N:* Is Respondent due any credit?

FINDINGS OF FACT

Petitioner filed two claims before the Illinois Workers' Compensation Commission. The first claim (13WC017920) filed on May 31, 2013 alleges an injury to the left shoulder and an accident date of May 20, 2013. Petitioner amended the initial claim Application, on July 1, 2013, to include the neck. On September 15, 2014, Petitioner filed another claim (14WC030834) alleging bilateral carpal tunnel syndrome and an accident date of July 1, 2014. On February 7, 2016, at the hearing, Petitioner made an oral motion to amend the date of accident to August 27, 2014 in case No: 14WC030834 without objection. The oral motion was granted and the claimed accident date was amended to August 27, 2014.

Petitioner testified he worked for Respondent, Tri Industries, on a part-time basis as a packager of printer cartridges. Petitioner began working for Respondent in July of 2012. Petitioner did work for Respondent after May 20, 2013. Petitioner worked three days a week for approximately 18-20 hours per week. (T. 33-34) Respondent is a nonprofit organization whose mission is to provide people with disabilities job opportunities and enhance their skills so they can find work in the community. (T.97) When Petitioner was hired by Respondent, he was actively treating for PTSD, PSD and depression at Heartland Health Center. (PX 2)

Petitioner testified that on, Monday, May 20, 2013, his supervisor, Doug Root, called him to the loading dock to unload a truck around 9 A.M. Petitioner said he went to the loading dock and started unloading the truck. Petitioner said he was unloading the truck for about 30-40 minutes. Petitioner said he unloaded the boxes from the back of a truck, which was about chest high, and the boxes weighed about 50 pounds.

On direct examination, Petitioner testified he felt a sharp pop in his left neck and shoulder area while unloading the fourth box from the truck. (T. 61) Petitioner said he unloaded the first three big boxes without any pain but experienced the paid while moving the fourth box. Petitioner said he immediately notified his supervisor of his

injury while still on the loading dock. After hurting his shoulder lifting the fourth box, Petitioner said he did not move any more boxes and he went to his workstation for about an hour before leaving work to go to the emergency room at around 11 A.M. (T. 61-64)

Doug Root, Petitioner's supervisor, testified Petitioner had taken off of work Friday May 17, 2013 to move out of his apartment. On Monday, May 20, 2013, between 8:30 A.M. and 9::00 A.M. a delivery truck arrived, before the shipping clerk started work, and Mr. Root asked Petitioner to assist him at the loading dock with a shipment. Mr. Root testified that Petitioner moved two boxes weighing about 36 pounds and two boxes weighing between 6 and 6 ½ pounds and the entire shipment took less than 5 minutes to unload. (T.120) Mr. Root said three people participated in the unloading of the shipment including the truck driver. Mr. Root testified Petitioner never reported any type of injury while on the loading dock. (T.122) Mr. Root said that around 11 A.M. Petitioner requested to leave work around 1:30 P.M. about 30 minutes early. Petitioner asked to skip lunch because he said "he had things to do". (T.124) Petitioner said his shoulder was bothering him. Mr. Root asked Petitioner if he had hurt his shoulder moving over the weekend and Petitioner responded "yeah". (T.126) Mr. Root was not aware that Petitioner was claiming he hurt himself at work until Mr. Root received a text message, from Petitioner, around 7:30 P.M. saying he was just released from Weiss Medical with a work related shoulder pull. (T.129)

On May 30, 2013, Doug Root and Petitioner completed an Incident Report Form. Petitioner admitted reviewing the form and authoring portions of the form. The form shows the time of the injured as 11:30 A.M. and that Petitioner left work at 1:30 P.M. (RX 2) Petitioner testified the time of the injury and the time he left work was not accurate on the form.

Anneliese Gallagher, the warehouse manager and safety officer, testified she spoke to Petitioner around 1:30 P.M. on May 20, 2013. She asked Petitioner why he was leaving work early. Petitioner said he hurt himself moving over the weekend. (T.140) Ms. Gallagher said that she was not advised of a work injury on May 20, 2013 and had an injury been reported she would have been notified as the safety officer. Dominique Epp, a customer service representative, testified she spoke to Petitioner on May 30, 2013 and he said that he hurt himself moving the day before. (147) Respondent denies he spoke to Ms. Gallagher and Ms. Epps on May 20, 2013 and claims they are lying. (T165)

Video of the Incident. Rx. 9

Respondent introduced into evidence, without objection, a video of the loading dock where Petitioner originally claimed the injury occurred. The video shows the boxes were not unloaded from a truck. The boxes had been taken out of the truck before Petitioner arrived. The boxes were located on ground next to the loading dock. The boxes were moved from the skid to a pallet jack. Doug Root, the driver of the truck and Petitioner participate in the moving of the boxes from the skid onto a pallet jack. The entire shipment consists of 10 larger boxes and 4 smaller boxes. Doug Root and the truck driver are seen moving the majority of the boxes while Petitioner is seen standing next to the skid watching Doug Root and the truck driver moving the boxes. Petitioner participated very little in the unloading of the boxes. Petitioner is seen only moving only 2 large boxes and a couple smaller boxes. The video shows the entire unloading process took less than 5 minutes. Petitioner is not seen lifting 4 larger boxes. Petitioner is not seen having a conversation with his supervisor, Doug Root. After the boxes are loaded onto the pallet jack, Petitioner is seen moving the pallet jack into the facility and returning to his workstation leaving the boxes on the pallet jack. (RX 9)

After watching the video, Petitioner was called as a rebuttal witness. Petitioner testified he did not injury himself on the loading dock while unloading the boxes from a truck as he originally testified. Petitioner now

claimed that the injury actually occurred in the warehouse, at a later time, not on camera. (T161, 162) Petitioner claims the video is missing 35 minutes and it took him between 30-40 minutes to unload the boxes. (T.165) Petitioner admitted that he walked away from the pallet jack, after moving it inside, and he didn't do anything with it. (T169, 170)

The Weiss Memorial Hospital emergency room records show that Petitioner arrived at the hospital at 17:38 on May 20, 2013. At that time, Petitioner said his problems started 4 hours ago while lifting a heavy object at work. Petitioner complained of posterior left shoulder and scapula pain. Petitioner was diagnosed with a shoulder strain. The examination showed no evidence of soft tissue swelling, normal AC joint exam, normal shoulder alignment, distal neurovascular exam was normal and full active and passive ROM to upper extremities was noted. (PX 1)

On May 22, 2013, Petitioner sought treatment from Heartland Health Center. Petitioner provided a history of lifting boxes at work Monday morning around 11 A.M. and he started to feel pain during the afternoon, applied Bengay which did not help, and the pain had become more extreme as day went on so he went to emergency room. (PX 2) The examination showed no erythema, no swelling, negative drop arm test, negative empty can, Neer, NFL Touchdown Test, negative push off test, negative Subacromial Impingement Test and Spurling Test. (PX 2)

On May 29, 2013, during a physical therapy appointment at Heartland Health Center, Petitioner said he hurt himself lifting heavy boxes above his head at work just over a week ago. The following day, Petitioner said he felt pain at work about one hour after stacking boxes. The Heartland Health Center records as of May 30, 2013 show Petitioner was not experiencing any numbness or tingling. (PX 2)

On June 3, 2013, Petitioner attended an examination at Heartland Health Center for his regular and consistent use of psychotropic medications as well as observance of medical and psychiatric advice in order to address psychiatric symptoms interfering with recovery. At that visit, Petitioner reported he was experiencing high stress because company had laid off 10 workers, his coworkers were not reliable and more duties were being given to Petitioner. Petitioner was also experiencing stress of his shoulder pain and he would be starting physical therapy. Petitioner moved 2 weeks ago because the landlord sold the building. (PX 2) In the medical records of Dr. Ladewski, from Heartland Health Center, dated June 17, 2013, Petitioner complained of tingling down his left arm. (PX 2)

Petitioner was referred to Dr. Patel, an orthopedic surgeon. At the initial examination, on October 30, 2013, Petitioner said he was at work lifting and unloading a truck when he had a severe pop in his neck and severe neck pain that progressively got worse and had left shoulder pain and right radiating arm pain symptoms. Petitioner described pain, numbness tingling down the entire arm into the hand on his right side. (PX 6). Dr. Patel diagnosed Petitioner as suffering C4-5 and C5-6 cervical spondylosis with radiculopathy and myelopathy. Dr. Patel recommended and subsequently performed an anterior C4-C5, C5-C6 discectomy decompression and fusion. (PX 6)

During his deposition, Dr. Patel acknowledged that his causal opinion was based upon the history provided by Petitioner and since Petitioner said he had no prior problems before the injury, he had to assume that it was the source of his symptoms. Dr. Patel further acknowledged that his opinion relied entirely on what was told to him by Petitioner regarding the mechanism of injury and subsequent symptoms. Dr. Patel admitted he did not did not review the medical records from Weiss Hospital or Heartland Health Center. In his deposition, Dr. Patel said if Petitioner reported to his original medical providers he only had left shoulder pain and no mention of a pop the history, he would find the history given to him as inconsistent. (PX 3)

Petitioner was examined by Dr. Zoellick, pursuant to Section 12 of the Act, on August 12, 2013, January 17, 2014 and October 26, 2015. At the initial examination Petitioner said on May 20, 2013 he was lifting and stacking 50 pound boxes of toner cartridges when he felt a sharp pain in his left shoulder. Dr. Zoellick testified Petitioner's cervical condition was not related to the work accident of May 20, 2013. Petitioner had cervical spondylosis, a pre-existing condition. (RX 6) Petitioner's condition involved degenerative changes of the cervical spine that was not caused or aggravated at work on May 20, 2013. Dr. Zoellick said Dr. Patel was provided a different history than provided to the other medical providers. Petitioner did not report a pop in his neck at the Weiss Memorial Hospital emergency room or to the physicians who treated Petitioner when he started treating at Heartland Health Center. (RX 6)

Regarding his cervical spine and his current condition, Petitioner testified that he is fine but he gets some stiffness and numbness in his neck when it is cold. Petitioner said that he could perform the same activities he did prior to May 20, 2013. (T.50, 51) A functional capacity evaluation was performed on July 7, 2014. The evaluation indicated that Petitioner was unable to perform the duties of a Cartridge Packager as outlined in the Functional Job Description provided to the evaluator and as the client reports. (PX 5)

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (*O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980)) including that the accidental injury both arose out of and occurred in the course of his employment (*Horath v. Industrial Commission*, 96 Ill 2d 349 (1983)) and that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc Co. v. Industrial Board*, 284 Ill. 378 (1918). To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 205 (2003). Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e).

The Arbitrator finds the testimony of Petitioner not to be credible.

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:

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Baggett v. Industrial Comm'n*, 201 Ill.2d. 187, 266 Ill.Dec. 836, 775 N.E.2d 908 (2002). The "arising out of" component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). An accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill.2d. 123, 227 N.E.2d 65 (1967). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered

in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 ILL.2d 214 (1969).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has not proven by a preponderance of the credible evidence that Petitioner had an accident that arose out of and in the course of his employment by Respondent sustained on May 20, 2013 as set forth more fully below.

Petitioner's testimony was not credible and contradictory. Petitioner originally testified that he was hurt while unloading boxes from the back of a truck that was about chest high. The original location of the accident was the loading dock. The video showed Petitioner did not unload a truck because the boxes were not on the back of a truck. Petitioner also said he was unloading the truck for about 30-40 minutes. The video and the testimony of his supervisor Doug Root showed the unloading process took under 5 minutes. The video shows Doug Root and the truck driver unloading most of the boxes while Petitioner watched. Petitioner only moved two of the larger boxes and a few of the smaller boxes. Petitioner was very specific that his injury occurred when he was unloading the fourth large box from the truck and he did not experience any pain while unloading the first three boxes. However, the video shows Petitioner unloaded only two large boxes. Petitioner said the large boxes weighed 50 pounds but the testimony of this supervisor, Doug Root, who weighed the boxes, said the box only weighed 36 pounds. Three witnesses testified that Petitioner told them he had injured his shoulder over the weekend while moving from his apartment. Petitioner denied he told the witnesses he hurt himself over the weekend moving.

After watching the video, Petitioner was called as a rebuttal witness, testified he was actually injured at a different location and time than he originally testified. On rebuttal, Petitioner testified he did not injury himself on the loading dock while unloading boxes from a truck as he originally testified. After viewing the video tape, Petitioner said he injured himself in the warehouse, at a later time, not on camera. (T161, 162) Petitioner claims he was injured unloading the pallet jack after it was brought into the warehouse. However, Petitioner testified he walked away from the pallet jack, after moving it inside, and didn't do anything later with it. (T169, 170) Petitioner testified that he was unloading boxes for 30-40 minutes but the video and testimony of his supervisor, Doug Root, shows the entire unloading process took less than 5 minutes. The Arbitrator finds the testimony of the supervisor, Doug Root, Anneliese Gallagher, Dominique Epp and Kenneth Bell to be credible.

Petitioner testified he immediately notified Doug Root of his injury on the loading dock. Doug Root testified Petitioner did not notify of him of an injury while on the loading dock and the unloading process was completed around 9 A.M. Doug Root testified that Petitioner approached him about 11 A.M. and asked to leave work at 1:30 P.M. because he had hurt himself while moving over the weekend. The first indication Petitioner was claiming he was injured came from a text message from Petitioner, around 7:30 P.M. saying he was just released from Weiss Medical with a work related shoulder pull. (T.129) The Arbitrator finds the timing of the text message to be consistent with the medical records from Weiss Memorial Hospital which shows Petitioner arrived at the hospital at 17:38 on May 20, 2013. Contrary to the Weiss Memorial Records, Petitioner testified he went to Weiss Memorial Hospital after leaving work around 11 A.M.

Arbitrator finds the histories Petitioner gave to the medical providers to be inconsistent. Petitioner testified that he while unloading boxes from the truck he felt a sharp pop in his left neck and shoulder area. (T.22, 23) The medical records from Weiss Memorial Hospital show Petitioner complained of posterior left shoulder and scapula pain after lifting a heavy object at work. (PX 1) Petitioner told Dr. Patel, he was at work lifting and unloading a truck when he had a severe pop in his neck and severe neck pain that progressively got worse and left shoulder pain and right radiating arm pain symptoms. Petitioner described pain, numbness and tingling

down the entire arm into the hand on his right side. (PX 6). The records from Weiss Memorial Hospital do not state that Petitioner felt a pop in his neck and severe neck pain, tingling and numbness going down Petitioner's right arm and the Heartland Health Center records dated May 30, 2013 show Petitioner was not experiencing any numbness or tingling. (PX 2)

On May 22, 2013, at Heartland Health Center, Petitioner said he was lifting boxes at work Monday morning around 11 A.M. and he started to feel pain during the afternoon and the pain had become more extreme as day went on so he went to emergency room. (PX 2) The examination was benign showing no erythema, no swelling, negative drop arm test, negative empty can, Neer, NFL Touchdown Test, negative push off test, negative Subacromial Impingement Test and Spurling Test. (PX 2) The records show Petitioner did complain of felling a pop in his neck and suffering from extreme neck pain. Petitioner was diagnosed with a shoulder strain. On May 29, 2013, during a physical therapy appointment, Petitioner said he hurt himself lifting heavy boxes, above his head at work, just over a week ago. The records do not contain any reference of experiencing a pop in the neck followed by severe neck pain, tingling and numbness down into his right hand. The Heartland Health Center records as of May 30, 2013 show Petitioner was not experiencing any numbness or tingling in his hands. (PX 2) The Arbitrator finds the physical therapy records from Weiss Memorial Hospital, dated June 11, 2013 to be reflective of the issue of credibility. The therapist noted that the patient grimaces when the therapist is in the room but is observed not grimacing when the therapist is not in the room. (RX 8)

During his deposition, Dr. Patel acknowledged his causal opinion was based upon the history provided by Petitioner. Dr. Patel acknowledged his opinion relied entirely on what was told to him by the Petitioner regarding the mechanism of injury and subsequent symptoms. Dr. Patel admitted he did not did not review the medical records from Weiss Hospital, Dr. Carrier or Trilogy. In his deposition, Dr. Patel said if Petitioner reported to his original medical providers he only had left shoulder pain and there was no mention of a pop the history, he would find the history given to him as inconsistent. (PX 3) The medical records from Weiss Hospital, Dr. Carrier and Heartland Health Center do not show Petitioner experienced a pop in his neck, sever neck pain and tingling or numbness in his right hand. Based upon the inaccurate history provided to Dr. Patel, the Arbitrator does not find his opinions persuasive because his opinions are based upon a flawed premise.

Dr. Zoellick, who performed several Section 12 examinations of Petitioner, reviewed the medical records from Dr. Patel, Weiss Memorial Hospital and Trilogy Heartland Health Center. Dr. Zoellick testified Petitioner had cervical spondylosis that was pre-existing condition and unrelated to the work accident. Dr. Zoellick further testified the events of May 20, 2013 did not aggravate or cause Petitioner's condition or the need for surgery. In support of his opinion Dr. Zoellick noted the severe pop in the neck Petitioner told Dr. Patel was not documented in the prior medical records and Petitioner did not have any right-sided complaints. The Arbitrator finds the testimony of Dr. Zoellick persuasive. Accordingly, the claim is denied.

WITH RESPECT TO ISSUES (J), (K), (L) AND (N) THE ARBITRATOR FINDS AS FOLLOWS:

In light of the determination that Petitioner failed to establish his condition was casually connected to the injury arising out of and in the course of his employment with Respondent, the remaining issues of Respondent's liability is moot and not reached by this Arbitrator. Accordingly, benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Germenie Ward,
Petitioner,

vs.

NO: 13 WC 17920,

18IWCC0471

TRI Industries,
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, 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, 2017 is hereby affirmed and adopted.

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

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

18IWCC0471

The party commencing 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:

Joshua D. Luskin

JUL 27 2018
o-07/25/18
jdl/wj
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WARD, GERMENIE
Employee/Petitioner

Case# **13WC017920**

14WC030834

TRI INDUSTRIES
Employer/Respondent

18IWCC0471

On 3/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0507 RUSIN & MACIOROWSKI LTD
JIGAR S DESAI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Germenie Ward
Employee/Petitioner

v.

TRI Industries
Employer/Respondent

Case # 13 WC 017920

Consolidated cases: 14WC030834

18IWCC0471

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **February 7, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 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 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 **$10,225.28**; the average weekly wage was **$196.64**.

On the date of accident, Petitioner was **41** 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 **$3,511.43** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,127.62** for other benefits, for a total credit of **$4,639.05**.

Respondent is entitled to a credit of any amounts paid in medical bills through its group medical plan pursuant to Section 8(j) 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.

ORDER

Claim for compensation is denied, Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on May 20, 2013.

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

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

3/22/2017
Date

MAR 23 2017

INTRODUCTION

This matter was tried with a consolidated case No. 14WC030834 which involves a different date of loss. The decision in 14WC030834 is being entered concurrently with this Decision. These matters proceeded to hearing before Arbitrator Frank Soto and the disputed issues were:

13 WC 17920 (DOI 5/20/2013): ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?, ***F:*** Is Petitioner's current condition of ill-being causally related to the injury?, ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary?, Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Whether or not TTD benefits are owed; ***L:***What is the nature and extent of the injury?; ***N:*** Is Respondent due any credit?

14 WC 030834 (DOI 8/27/2014): ***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 injury?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; *K.* Whether or not TTD benefits are owed? ***L:***What is the nature and extent of the injury? ***N:*** Is Respondent due any credit?

FINDINGS OF FACT

Petitioner filed two claims before the Illinois Workers' Compensation Commission. The first claim (13WC017920) filed on May 31, 2013 alleges an injury to the left shoulder and an accident date of May 20, 2013. Petitioner amended the initial claim Application, on July 1, 2013, to include the neck. On September 15, 2014, Petitioner filed another claim (14WC030834) alleging bilateral carpal tunnel syndrome and an accident date of July 1, 2014. On February 7, 2016, at the hearing, Petitioner made an oral motion to amend the date of accident to August 27, 2014 in case No: 14WC030834 without objection. The oral motion was granted and the claimed accident date was amended to August 27, 2014.

Petitioner testified he worked for Respondent, Tri Industries, on a part-time basis as a packager of printer cartridges. Petitioner began working for Respondent in July of 2012. Petitioner did work for Respondent after May 20, 2013. Petitioner worked three days a week for approximately 18-20 hours per week. (T. 33-34) Respondent is a nonprofit organization whose mission is to provide people with disabilities job opportunities and enhance their skills so they can find work in the community. (T.97) When Petitioner was hired by Respondent, he was actively treating for PTSD, PSD and depression at Heartland Health Center. (PX 2)

Petitioner testified that on, Monday, May 20, 2013, his supervisor, Doug Root, called him to the loading dock to unload a truck around 9 A.M. Petitioner said he went to the loading dock and started unloading the truck. Petitioner said he was unloading the truck for about 30-40 minutes. Petitioner said he unloaded the boxes from the back of a truck, which was about chest high, and the boxes weighed about 50 pounds.

On direct examination, Petitioner testified he felt a sharp pop in his left neck and shoulder area while unloading the fourth box from the truck. (T. 61) Petitioner said he unloaded the first three big boxes without any pain but experienced the paid while moving the fourth box. Petitioner said he immediately notified his supervisor of his

injury while still on the loading dock. After hurting his shoulder lifting the fourth box, Petitioner said he did not move any more boxes and he went to his workstation for about an hour before leaving work to go to the emergency room at around 11 A.M. (T. 61-64)

Doug Root, Petitioner's supervisor, testified Petitioner had taken off of work Friday May 17, 2013 to move out of his apartment. On Monday, May 20, 2013, between 8:30 A.M. and 9::00 A.M. a delivery truck arrived, before the shipping clerk started work, and Mr. Root asked Petitioner to assist him at the loading dock with a shipment. Mr. Root testified that Petitioner moved two boxes weighing about 36 pounds and two boxes weighing between 6 and 6 ½ pounds and the entire shipment took less than 5 minutes to unload. (T.120) Mr. Root said three people participated in the unloading of the shipment including the truck driver. Mr. Root testified Petitioner never reported any type of injury while on the loading dock. (T.122) Mr. Root said that around 11 A.M. Petitioner requested to leave work around 1:30 P.M. about 30 minutes early. Petitioner asked to skip lunch because he said "he had things to do". (T.124) Petitioner said his shoulder was bothering him. Mr. Root asked Petitioner if he had hurt his shoulder moving over the weekend and Petitioner responded "yeah". (T.126) Mr. Root was not aware that Petitioner was claiming he hurt himself at work until Mr. Root received a text message, from Petitioner, around 7:30 P.M. saying he was just released from Weiss Medical with a work related shoulder pull. (T.129)

On May 30, 2013, Doug Root and Petitioner completed an Incident Report Form. Petitioner admitted reviewing the form and authoring portions of the form. The form shows the time of the injured as 11:30 A.M. and that Petitioner left work at 1:30 P.M. (RX 2) Petitioner testified the time of the injury and the time he left work was not accurate on the form.

Anneliese Gallagher, the warehouse manager and safety officer, testified she spoke to Petitioner around 1:30 P.M. on May 20, 2013. She asked Petitioner why he was leaving work early. Petitioner said he hurt himself moving over the weekend. (T.140) Ms. Gallagher said that she was not advised of a work injury on May 20, 2013 and had an injury been reported she would have been notified as the safety officer. Dominique Epp, a customer service representative, testified she spoke to Petitioner on May 30, 2013 and he said that he hurt himself moving the day before. (147) Respondent denies he spoke to Ms. Gallagher and Ms. Epps on May 20, 2013 and claims they are lying. (T165)

Video of the Incident, Rx. 9

Respondent introduced into evidence, without objection, a video of the loading dock where Petitioner originally claimed the injury occurred. The video shows the boxes were not unloaded from a truck. The boxes had been taken out of the truck before Petitioner arrived. The boxes were located on ground next to the loading dock. The boxes were moved from the skid to a pallet jack. Doug Root, the driver of the truck and Petitioner participate in the moving of the boxes from the skid onto a pallet jack. The entire shipment consists of 10 larger boxes and 4 smaller boxes. Doug Root and the truck driver are seen moving the majority of the boxes while Petitioner is seen standing next to the skid watching Doug Root and the truck driver moving the boxes. Petitioner participated very little in the unloading of the boxes. Petitioner is seen only moving only 2 large boxes and a couple smaller boxes. The video shows the entire unloading process took less than 5 minutes. Petitioner is not seen lifting 4 larger boxes. Petitioner is not seen having a conversation with his supervisor, Doug Root. After the boxes are loaded onto the pallet jack, Petitioner is seen moving the pallet jack into the facility and returning to his workstation leaving the boxes on the pallet jack. (RX 9)

After watching the video, Petitioner was called as a rebuttal witness. Petitioner testified he did not injury himself on the loading dock while unloading the boxes from a truck as he originally testified. Petitioner now

claimed that the injury actually occurred in the warehouse, at a later time, not on camera. (T161, 162) Petitioner claims the video is missing 35 minutes and it took him between 30-40 minutes to unload the boxes. (T.165) Petitioner admitted that he walked away from the pallet jack, after moving it inside, and he didn't do anything with it. (T169, 170)

The Weiss Memorial Hospital emergency room records show that Petitioner arrived at the hospital at 17:38 on May 20, 2013. At that time, Petitioner said his problems started 4 hours ago while lifting a heavy object at work. Petitioner complained of posterior left shoulder and scapula pain. Petitioner was diagnosed with a shoulder strain. The examination showed no evidence of soft tissue swelling, normal AC joint exam, normal shoulder alignment, distal neurovascular exam was normal and full active and passive ROM to upper extremities was noted. (PX 1)

On May 22, 2013, Petitioner sought treatment from Heartland Health Center. Petitioner provided a history of lifting boxes at work Monday morning around 11 A.M. and he started to feel pain during the afternoon, applied Bengay which did not help, and the pain had become more extreme as day went on so he went to emergency room. (PX 2) The examination showed no erythema, no swelling, negative drop arm test, negative empty can, Neer, NFL Touchdown Test, negative push off test, negative Subacromial Impingement Test and Spurling Test. (PX 2)

On May 29, 2013, during a physical therapy appointment at Heartland Health Center, Petitioner said he hurt himself lifting heavy boxes above his head at work just over a week ago. The following day, Petitioner said he felt pain at work about one hour after stacking boxes. The Heartland Health Center records as of May 30, 2013 show Petitioner was not experiencing any numbness or tingling. (PX 2)

On June 3, 2013, Petitioner attended an examination at Heartland Health Center for his regular and consistent use of psychotropic medications as well as observance of medical and psychiatric advice in order to address psychiatric symptoms interfering with recovery. At that visit, Petitioner reported he was experiencing high stress because company had laid off 10 workers, his coworkers were not reliable and more duties were being given to Petitioner. Petitioner was also experiencing stress of his shoulder pain and he would be starting physical therapy. Petitioner moved 2 weeks ago because the landlord sold the building. (PX 2) In the medical records of Dr. Ladewski, from Heartland Health Center, dated June 17, 2013, Petitioner complained of tingling down his left arm. (PX 2)

Petitioner was referred to Dr. Patel, an orthopedic surgeon. At the initial examination, on October 30, 2013, Petitioner said he was at work lifting and unloading a truck when he had a severe pop in his neck and severe neck pain that progressively got worse and had left shoulder pain and right radiating arm pain symptoms. Petitioner described pain, numbness tingling down the entire arm into the hand on his right side. (PX 6). Dr. Patel diagnosed Petitioner as suffering C4-5 and C5-6 cervical spondylosis with radiculopathy and myelopathy. Dr. Patel recommended and subsequently performed an anterior C4-C5, C5-C6 discectomy decompression and fusion. (PX 6)

During his deposition, Dr. Patel acknowledged that his causal opinion was based upon the history provided by Petitioner and since Petitioner said he had no prior problems before the injury, he had to assume that it was the source of his symptoms. Dr. Patel further acknowledged that his opinion relied entirely on what was told to him by Petitioner regarding the mechanism of injury and subsequent symptoms. Dr. Patel admitted he did not did not review the medical records from Weiss Hospital or Heartland Health Center. In his deposition, Dr. Patel said if Petitioner reported to his original medical providers he only had left shoulder pain and no mention of a pop the history, he would find the history given to him as inconsistent. (PX 3)

Petitioner was examined by Dr. Zoellick, pursuant to Section 12 of the Act, on August 12, 2013, January 17, 2014 and October 26, 2015. At the initial examination Petitioner said on May 20, 2013 he was lifting and stacking 50 pound boxes of toner cartridges when he felt a sharp pain in his left shoulder. Dr. Zoellick testified Petitioner's cervical condition was not related to the work accident of May 20, 2013. Petitioner had cervical spondylosis, a pre-existing condition. (RX 6) Petitioner's condition involved degenerative changes of the cervical spine that was not caused or aggravated at work on May 20, 2013. Dr. Zoellick said Dr. Patel was provided a different history than provided to the other medical providers. Petitioner did not report a pop in his neck at the Weiss Memorial Hospital emergency room or to the physicians who treated Petitioner when he started treating at Heartland Health Center. (RX 6)

Regarding his cervical spine and his current condition, Petitioner testified that he is fine but he gets some stiffness and numbness in his neck when it is cold. Petitioner said that he could perform the same activities he did prior to May 20, 2013. (T.50, 51) A functional capacity evaluation was performed on July 7, 2014. The evaluation indicated that Petitioner was unable to perform the duties of a Cartridge Packager as outlined in the Functional Job Description provided to the evaluator and as the client reports. (PX 5)

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (*O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980)) including that the accidental injury both arose out of and occurred in the course of his employment (*Horath v. Industrial Commission*, 96 Ill 2d 349 (1983)) and that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc Co. v. Industrial Board*, 284 Ill. 378 (1918). To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 205 (2003). Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e).

The Arbitrator finds the testimony of Petitioner not to be credible.

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:

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Baggett v. Industrial Comm'n*, 201 Ill.2d. 187, 266 Ill.Dec. 836, 775 N.E.2d 908 (2002). The "arising out of" component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). An accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill.2d. 123, 227 N.E.2d 65 (1967). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered

in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 ILL.2d 214 (1969).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has not proven by a preponderance of the credible evidence that Petitioner had an accident that arose out of and in the course of his employment by Respondent sustained on May 20, 2013 as set forth more fully below.

Petitioner's testimony was not credible and contradictory. Petitioner originally testified that he was hurt while unloading boxes from the back of a truck that was about chest high. The original location of the accident was the loading dock. The video showed Petitioner did not unload a truck because the boxes were not on the back of a truck. Petitioner also said he was unloading the truck for about 30-40 minutes. The video and the testimony of his supervisor Doug Root showed the unloading process took under 5 minutes. The video shows Doug Root and the truck driver unloading most of the boxes while Petitioner watched. Petitioner only moved two of the larger boxes and a few of the smaller boxes. Petitioner was very specific that his injury occurred when he was unloading the fourth large box from the truck and he did not experience any pain while unloading the first three boxes. However, the video shows Petitioner unloaded only two large boxes. Petitioner said the large boxes weighed 50 pounds but the testimony of this supervisor, Doug Root, who weighed the boxes, said the box only weighed 36 pounds. Three witnesses testified that Petitioner told them he had injured his shoulder over the weekend while moving from his apartment. Petitioner denied he told the witnesses he hurt himself over the weekend moving.

After watching the video, Petitioner was called as a rebuttal witness, testified he was actually injured at a different location and time than he originally testified. On rebuttal, Petitioner testified he did not injury himself on the loading dock while unloading boxes from a truck as he originally testified. After viewing the video tape, Petitioner said he injured himself in the warehouse, at a later time, not on camera. (T161, 162) Petitioner claims he was injured unloading the pallet jack after it was brought into the warehouse. However, Petitioner testified he walked away from the pallet jack, after moving it inside, and didn't do anything later with it. (T169, 170) Petitioner testified that he was unloading boxes for 30-40 minutes but the video and testimony of his supervisor, Doug Root, shows the entire unloading process took less than 5 minutes. The Arbitrator finds the testimony of the supervisor, Doug Root, Anneliese Gallagher, Dominique Epp and Kenneth Bell to be credible.

Petitioner testified he immediately notified Doug Root of his injury on the loading dock. Doug Root testified Petitioner did not notify of him of an injury while on the loading dock and the unloading process was completed around 9 A.M. Doug Root testified that Petitioner approached him about 11 A.M. and asked to leave work at 1:30 P.M. because he had hurt himself while moving over the weekend. The first indication Petitioner was claiming he was injured came from a text message from Petitioner, around 7:30 P.M. saying he was just released from Weiss Medical with a work related shoulder pull. (T.129) The Arbitrator finds the timing of the text message to be consistent with the medical records from Weiss Memorial Hospital which shows Petitioner arrived at the hospital at 17:38 on May 20, 2013. Contrary to the Weiss Memorial Records, Petitioner testified he went to Weiss Memorial Hospital after leaving work around 11 A.M.

Arbitrator finds the histories Petitioner gave to the medical providers to be inconsistent. Petitioner testified that he while unloading boxes from the truck he felt a sharp pop in his left neck and shoulder area. (T.22, 23) The medical records from Weiss Memorial Hospital show Petitioner complained of posterior left shoulder and scapula pain after lifting a heavy object at work. (PX 1) Petitioner told Dr. Patel, he was at work lifting and unloading a truck when he had a severe pop in his neck and severe neck pain that progressively got worse and left shoulder pain and right radiating arm pain symptoms. Petitioner described pain, numbness and tingling

down the entire arm into the hand on his right side. (PX 6). The records from Weiss Memorial Hospital do not state that Petitioner felt a pop in his neck and severe neck pain, tingling and numbness going down Petitioner's right arm and the Heartland Health Center records dated May 30, 2013 show Petitioner was not experiencing any numbness or tingling. (PX 2)

On May 22, 2013, at Heartland Health Center, Petitioner said he was lifting boxes at work Monday morning around 11 A.M. and he started to feel pain during the afternoon and the pain had become more extreme as day went on so he went to emergency room. (PX 2) The examination was benign showing no erythema, no swelling, negative drop arm test, negative empty can, Neer, NFL Touchdown Test, negative push off test, negative Subacromial Impingement Test and Spurling Test. (PX 2) The records show Petitioner did complain of felling a pop in his neck and suffering from extreme neck pain. Petitioner was diagnosed with a shoulder strain. On May 29, 2013, during a physical therapy appointment, Petitioner said he hurt himself lifting heavy boxes, above his head at work, just over a week ago. The records do not contain any reference of experiencing a pop in the neck followed by severe neck pain, tingling and numbness down into his right hand. The Heartland Health Center records as of May 30, 2013 show Petitioner was not experiencing any numbness or tingling in his hands. (PX 2) The Arbitrator finds the physical therapy records from Weiss Memorial Hospital, dated June 11, 2013 to be reflective of the issue of credibility. The therapist noted that the patient grimaces when the therapist is in the room but is observed not grimacing when the therapist is not in the room. (RX 8)

During his deposition, Dr. Patel acknowledged his causal opinion was based upon the history provided by Petitioner. Dr. Patel acknowledged his opinion relied entirely on what was told to him by the Petitioner regarding the mechanism of injury and subsequent symptoms. Dr. Patel admitted he did not did not review the medical records from Weiss Hospital, Dr. Carrier or Trilogy. In his deposition, Dr. Patel said if Petitioner reported to his original medical providers he only had left shoulder pain and there was no mention of a pop the history, he would find the history given to him as inconsistent. (PX 3) The medical records from Weiss Hospital, Dr. Carrier and Heartland Health Center do not show Petitioner experienced a pop in his neck, sever neck pain and tingling or numbness in his right hand. Based upon the inaccurate history provided to Dr. Patel, the Arbitrator does not find his opinions persuasive because his opinions are based upon a flawed premise.

Dr. Zoellick, who performed several Section 12 examinations of Petitioner, reviewed the medical records from Dr. Patel, Weiss Memorial Hospital and Trilogy Heartland Health Center. Dr. Zoellick testified Petitioner had cervical spondylosis that was pre-existing condition and unrelated to the work accident. Dr. Zoellick further testified the events of May 20, 2013 did not aggravate or cause Petitioner's condition or the need for surgery. In support of his opinion Dr. Zoellick noted the severe pop in the neck Petitioner told Dr. Patel was not documented in the prior medical records and Petitioner did not have any right-sided complaints. The Arbitrator finds the testimony of Dr. Zoellick persuasive. Accordingly, the claim is denied.

WITH RESPECT TO ISSUES (J), (K), (L) AND (N) THE ARBITRATOR FINDS AS FOLLOWS:

In light of the determination that Petitioner failed to establish his condition was casually connected to the injury arising out of and in the course of his employment with Respondent, the remaining issues of Respondent's liability is moot and not reached by this Arbitrator. Accordingly, benefits are denied.

16WC25760
Page 1

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

Craig A. Carpentier,
Petitioner,
vs.

NO: 16 WC 25760

State of Illinois DHS,
Respondent.

18IWCC0472

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 6, 2017, is hereby affirmed and adopted.

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

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

DATED:
o071218
DLG/mw
045

JUL 30 2018

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARPENTIER, CRAIG A
Employee/Petitioner

Case# **16WC025760**

STATE OF ILLINOIS DHS
Employer/Respondent

18IWCC0472

On 12/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.45% 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:

2427 KANOSKI BRESNEY
KATHY A OLIVERO
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

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

6790 ASSISTANT ATTORNEY GENERAL
BRADLEY DEFREITAS
500 S SECOND ST
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

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

DEC 6 - 2017

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

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Craig A. Carpentier
Employee/Petitioner

v.

State of Illinois DHS
Employer/Respondent

Case # 16 WC 25760

Consolidated cases: None

18IWCC0472

An *Application for Adjustment 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 October 24, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 28, 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 $87,563.32; the average weekly wage was $1,683.91.

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

Respondent shall be given a credit of $25,981.78 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $25,981.78.

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

ORDER

- Respondent shall pay Petitioner temporary total disability benefits of **$1,122.61**/week for 23 3/7 weeks from 1/19/16 through 6/30/16.
- Respondent shall pay Petitioner the sum of **$735.37**/week for a further period of 37.63 weeks, as provided in Section 8(e)(12) of the Act, because the injuries sustained caused the permanent disability of the left leg to the extent of 17.5 % thereof.
- Respondent shall pay Petitioner compensation that has accrued from 5/28/15 through 10/24/17, and shall pay the remainder of the award, if any, in weekly payments.
- Respondent shall pay the further sum of **$12,554.67** for necessary medical services, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act, and shall be given a credit for payments made by the group medical plan, and shall hold Petitioner harmless from any and all claims by any provider of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

D. Dylan McCarty

12/1/2017

DEC 6 - 2017

Signature of Arbitrator

Date

The Arbitrator hereby makes the following Findings of Facts on all issues:

Petitioner has been an employee of Respondent, n/k/a the Department of Information Technology, since August of 1993. On 5/28/15, Petitioner held the position of Senior Public Service Administrator and IT Manager for the Division of Rehabilitation Services, where he supervised 15 software engineers, wrote and maintained web based and case management applications, and managed the payroll system for all personal assistants and other medical personnel who provide services to the home services program. Petitioner performs most of his duties in a sitting position but also has to stand and walk because of meetings held in hallways and cubes, and because his office is a distance from the restroom PX 4).

On 5/28/15, Petitioner slid on some water on the floor near the water fountain, twisting his left knee and then slamming it into the wall (PX 5). Petitioner noticed discomfort in his entire left knee but did not seek immediate medical attention for his complaints, other than mentioning it to his family physician, Dr. Bova. Sometime later, Petitioner went to the orthopedic surgeon, Dr. Ludwig.

The records of Orthopedic Center of Illinois (OCI) reported Petitioner was seen by Dr. Ludwig on 9/16/15, with complaints of left anterior and medial knee pain, Petitioner had been injured at work, the injury resulted from twisting in May 2015 when Petitioner slipped on some water on the floor and twisted the knee (PX 1, p. 2). Petitioner also reported swelling, stiffness, clicking, instability, limping, and decreased range of motion of the left knee. On examination, Dr. Ludwig found swelling, grade 1 effusion, tenderness to palpation of the medial joint line, and range of motion was 0/95 degrees (PX 1, p. 2-3). X-rays showed slight narrowing of the medial compartment with some moderate patellofemoral arthritis on the right and mild patellofemoral arthritis on the left of the left knee (PX 1, p. 7). Dr. Ludwig diagnosed Petitioner with knee pain, acute, left, and osteoarthritis, localized, primary knee, left, and proceeded to aspirate the left knee and administer a cortisone injection to it.

Petitioner returned to OCI on 10/6/15, and reported his pain was worse and the knee was giving out on him and caused him to fall down 8 steps (PX 1, p. 8). This was also reported to Dr. Bova on 10/7/15 (PX 2, p. 30). Petitioner described the pain as aching and also a sharp pain with certain movement, there was catching and grinding, and Petitioner's range of motion was decreased. On examination, Dr. Ludwig found swelling, grade 1 effusion, tenderness to palpation of the medial joint line, a positive McMurray's test, a positive patellofemoral compression test, and there was 2+ crepitus present during range of motion. Dr. Ludwig noted Petitioner's exam was consistent with a torn medial meniscus and mild arthritis and recommended an MRI of the left knee (PX 1, p. 9).

The MRI was performed on 10/15/15, and interpreted by the radiologist as showing a large knee joint effusion with fibrinous debris within the effusion extensively, a complex tear of the posterior horn and body of the medial meniscus with contour deformity and fraying, full thickness loss of medial compartment articular cartilage of the tibial and femoral surfaces, subchondral edema at the weightbearing surface of the femur, the patellofemoral articular cartilage showed moderate extensive articular cartilage loss with fibrillation and cartilage heterogeneity in the patella and trochlear articular cartilage, and the patella was mildly subluxed laterally which may be secondary to the large joint effusion (PX 1, p. 14-15).

Petitioner returned to OCI on 10/21/15, and Dr. Ludwig recommended Petitioner proceed with arthroscopic evaluation of the knee (PX 1, p. 20). Petitioner returned to OCI on 12/16/15, and reported

he was working on approval from work comp for the left knee surgery, but was having increased left knee pain with walking, climbing stairs, weight bearing, and twisting (PX 1, p. 24). Dr. Ludwig noted his office was unable to get ahold of the workman's comp by phone as well, and that Petitioner will call when he has it sorted out (PX 1, p. 25).

On 1/19/16, Petitioner underwent a left knee arthroscopy with partial arthroscopic medial and lateral meniscectomies, removal of loose bodies, and debridement of patellofemoral joint and medial compartment (PX 1, p. 32-33). Dr. Ludwig described multiple minimally attached loose bodies in the suprapatellar pouch and one loose body in the lateral gutter, the patellofemoral joint had grade 3 chondromalacia involving a large portion of the patella as well as the trochanter groove, some loose articular cartilage was debrided back in the patellofemoral joint, there was an obvious tear involving the posterior horn and body of the medial meniscus, and there was a small flap tear involving the posterior horn of the lateral meniscus.

Petitioner returned to OCI on 1/25/16, and reported joint swelling and calf swelling, and was using an assistive device for ambulation and weight-bearing as tolerated. On examination, Dr. Ludwig found bruising along the medial aspect of the distal thigh, the leg was visibly swollen, the calf measured 5 cm larger than the opposite calf, and both legs had some pitting edema (PX 1, p. 38). Dr. Ludwig was concerned about a DVT and recommended a venous Doppler, which was performed on 1/25/16, and showed no evidence of acute deep vein thrombosis (PX 3, p.7).

Petitioner returned to OCI on 2/25/16 and 3/30/16, and continued to report pain, some days were worse than others, a popping and swelling in the left knee, and an occasional sharp pain (PX 1, p. 42, 60). On examination, Dr. Ludwig found swelling and restricted flexion, and thought it reasonable to proceed with a Synvisc injection (PX 1, p. 60). On 4/25/16, Petitioner underwent a Synvisc injection to the left knee (PX 1, p. 65).

Petitioner also received post-surgical physical therapy from 3/2/16 through 3/17/16, and the therapist reported prior to the injury, Petitioner had no difficulty, but currently was impaired with all weight bearing activities, walking, squatting, and had a LEFS score of 12 (PX 1, p. 46-57). On examination, the therapist found minimal edema in the knee complex, moderate gait antalgia with reduced weight bearing left lower extremity, severe tenderness to palpation at left lateral leg and medial thigh, pain and difficulty with sit to stand, squat, kneel, lunge, and pain with walking and stairs (PX 2, p. 47). These findings were repeatedly found by the therapist throughout the time Petitioner received physical therapy.

Petitioner returned to OCI on 6/13/16, and reported he had relief for about a month following the injection, but was back to limping and having constant pain that increased with walking, weight bearing, and going down stairs (PX 1, p. 69). Petitioner rated his pain to be 6/10 and Dr. Ludwig allowed Petitioner to return to work on 7/1/16 (PX 1, p. 69).

When Petitioner returned to work, he reported his left knee never stopped hurting and if he had been sitting for any length of time, it took awhile for the leg to ease up and he limped.
Petitioner returned again to OCI on 8/2/16, and reported he was still having pain with walking, he was limping, and there was catching and snapping in the knee (PX 1, p. 83). On examination, Dr. Ludwig found swelling and restricted flexion, and instructed Petitioner to use the left knee as tolerated, use over the counter anti-inflammatory agents, and opined from the standpoint of the arthroscopy, Petitioner was

at maximum medical improvement, but has arthritis that could require treatment in the future such as Visco supplementation shots and in the long term, a total knee replacement, and noted the next time Petitioner could proceed with a Synvisc injection was November 2016. Dr. Ludwig diagnosed tear of medial meniscus of knee, left, subsequent encounter and osteoarthritis, localized, primary, knee, left.

Petitioner returned to OCI again on 10/19/16, and reported he was still having pain with walking, was limping, has catching, and can hear snapping in the knee (PX 1, p. 107). On examination, Dr. Ludwig found a small effusion, range of motion was 0-120 degrees, there was tenderness along the medial joint line and with patellofemoral compression, and there was 2+ crepitation with active extension (PX 1, p. 107). Dr. Ludwig recommended another Synvisc injection which was performed on 1/4/17 (PX 1, p. 114-117). Petitioner received a third Synvisc injection on 8/21/17 (PX 1, p. 151-154).

Medical bills incurred by Petitioner in treatment of his left knee were contained in PX 6. This exhibit showed balances due the Orthopedic Center of Illinois in the sum of $10,946.67, Dr. Bova in the sum of $420.00, and Anesthesia Business Consultants in the sum of $1,188.00, or a total of $12,554.67.

Petitioner reported the injections he received in January and August of this year provided him with very little relief. Petitioner indicated the left knee never stops hurting, there is swelling, and the pain on the inside of his left knee has caused him to fall down the stairs a couple of times. Petitioner also expressed the pain he has in the left knee makes it difficult for him to concentrate when he works on complex algorithms and other things, so this makes his job a lot harder.

Petitioner also reported he limps a lot and has been unable to do work at his home including mowing the lawn because of the jarring from the riding mower, weed eating, and maintaining the pathways through the woods. Petitioner has difficulty riding on the passenger side of a vehicle and getting on and off his motorcycle as well as parking it, but no difficulty riding on the motorcycle. However, Petitioner does not ride his motorcycle as much as he used to.

Petitioner noted his injuries to the left knee had not had any effect on his future earning capacity as he is earning the same amount he did at the time of the accident. Petitioner thought his age effected the period of time it took him to heal from his injuries. Petitioner does not have any appointments scheduled with Dr. Ludwig as he has to wait another 5 months before another injection can be administered to his left knee.

Therefore, the Arbitrator concludes as follows:

Pursuant to Section 8.1b of the Act for accidental injuries that occur on or after 9/1/11, in determining the level of permanent partial disability, the Commission shall base its determination on several factors, including (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 injury, (iv) the employee's future earning capacity, and (v) the evidence of disability corroborated by the treating medical records, and further provides no single enumerated factor shall be the sole determinant of disability.

With regard to Section 8.1b(b)(i) of the Act, no weight should be given to this factor as neither party submitted a reported level of impairment pursuant to subsection (a).

With regard to Section 8.1b(b)(ii) of the Act, the evidence showed Petitioner was a Senior Public Service Administrator and IT Manager for the Division of Rehabilitation Services at the time of the accident and at the time of the arbitration hearing. He testified that the job was mostly sitting, with some standing and walking to attend meetings, go to the rest room and the like. Petitioner expressed the pain in his knee makes it more difficult for him to concentrate when he works on complex algorithms and other work, so this makes his job a lot harder to do. Inasmuch as the medical evidence shows the Petitioner with an unusually long period of post surgical pain, the Arbitrator feels his testimony credible with regards to his ability to concentrate. The Arbitrator gives some weight to this factor.

With regard to Section 8.1b(b)(iii) of the Act, substantial weight should be given to this factor as the undisputed evidence showed Petitioner was 62 years of age at the time of the injury. At his age, he will not experience a long work life wherein he would notice the adverse effects of his injury.

With regard to Section 8.1b(b)(iv) of the Act, little if any weight should be given to this factor, as the undisputed evidence showed the injuries to Petitioner's left knee had not had any effect on Petitioner's future earning capacity.

With regard to Section 8.1b(b)(v) of the Act, considerable weight should be given to this factor, as the undisputed evidence showed Petitioner sustained an injury to his left knee which required a surgical procedure that included removal of multiple minimally attached loose bodies in the suprapatellar pouch and one loose body in the lateral gutter, debridement of the patellofemoral joint and medial compartment, a meniscectomy for tears in the posterior horn and body of the medial meniscus, and a meniscectomy for a tear involving the posterior horn of the lateral meniscus. The undisputed evidence further showed that despite this surgery, Petitioner continued to experience symptoms of pain in the left knee, increased pain in the left knee with walking, weight bearing, and going down stairs, popping and swelling in the left knee, catching and snapping in the left knee, and occasional sharp pain in the medial compartment of the left knee that caused Petitioner to fall (PX 1). In addition, the undisputed evidence showed Petitioner continued to exhibit findings on physical examination of the left knee that included swelling, restricted flexion, tenderness to palpation, and 2+ crepitation with active extension. The undisputed evidence also showed Petitioner continues to receive injections to his left knee as needed and permitted. Petitioner credibly testified to personal activities he has modified or been restricted in performing and the difficulty he has concentrating due to the pain he experiences in the left knee, even though it has been more than 2 years since the date of accident.

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

Timothy Pierce,
Petitioner,
vs.

NO: 12 WC 13274

Booth Heating & Air Conditioning,
Respondent.

18IWCC0473

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 6, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,000.00. 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: JUL 30 2018
o071218
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PIERCE, TIMOTHY
Employee/Petitioner

Case# **12WC013274**

BOOTH HEATING & AIR CONDITIONING
Employer/Respondent

18IWCC0473

On 12/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.45% 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
TIMOTHY M SHAY
1030 DURKIN DR
SPRINGFIELD, IL 62704

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

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

Timothy Pierce
Employee/Petitioner

v.

Booth Heating & Air Conditioning
Employer/Respondent

Case # 12 WC 13274

Consolidated cases: _____

18IWCC0473

An *Application for Adjustment 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 **October 23, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$51,605.84**; the average weekly wage was **$992.42**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$26,030.76** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$26,030.76**.

Respondent is entitled to a credit of **$0** 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 31, except for the charges related to the carpal tunnel syndrome, directly to the providers, according to the fee schedule, as provided in Section 8(a) of the Act.

Respondent shall reimburse IDPH for amounts paid towards Petitioner's medical bills, as set forth in Petitioner's Exhibit 32, in accordance with the medical fee schedule.

Respondent shall receive a credit for all benefits previously paid to medical providers, as set forth in Respondent's Exhibit 8.

Temporary Partial Disability

Respondent shall pay Petitioner temporary total disability benefits of $661.61/week for 49 5/7 weeks, commencing September 29, 2011 through June 16, 2012 and February 10, 2015 through May 7, 2015, as provided in Section 8(a) of the Act.

Respondent shall receive a credit of $26,030.76 for temporary total disability benefits previously paid.

Permanent Partial Disability

Based on the factors set forth in the conclusions of law below, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of the person as a whole pursuant to §8(d)(2) of the Act for his injuries. Respondent shall pay Petitioner permanent partial disability benefits of $595.45 per week for a period of 50 weeks for injuries.

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

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

Signature of Arbitrator

11/29/2017
Date

DEC 6 - 2017

FINDINGS OF FACT

The Petitioner is currently 60 years of age. He has an eighth grade education, and has not obtained a GED. Petitioner is not currently employed. He was a member of the Laborer's Local 477 Union for 25 years during which time he worked for various employers performing physical labor through the union. Petitioner testified that some of employers through the union included KLP Gas Company, a bridge building company, and the Respondent. Prior to joining the union, Petitioner held a number of other jobs, often for short periods of time, all of which involved manual labor of some nature. The Plaintiff's last place of employment was for the Respondent. Petitioner has received Social Security Disability benefits since October of 2016.

The Petitioner testified he had worked for Respondent on two separate occasions. During his first round of employment by Respondent, he was working in Athens building geothermal wells. The second job, during which he suffered the accident and injuries set forth in the present claim, Plaintiff was working on a project at Jefferson Middle School in Springfield, Illinois. In this position, he was responsible for changing out drill bits on the well-drilling equipment. Petitioner testified that the drill was "huge" and that it would drill 200 feet in the ground for geothermal wells.

Petitioner testified that on September 28, 2011, he was taking a drill bit off the drill. He testified he was standing on a platform that was approximately 18 inches to 2 feet off of the ground. Petitioner testified it was his understanding that the drill operator hit the wrong button on the drill and the drill went into reverse, which put the machine in a bind, and caused a gate on the platform to swing and impact the Petitioner. Petitioner was hit in the waist area and was pushed backward, approximately five feet up into the air and approximately 12 to 14 feet backward. Petitioner landed on his neck, right shoulder, and right hand. He testified that he was knocked unconscious for approximately thirty seconds after impact.

Petitioner initially presented to the emergency department at St. John's Hospital on September 29, 2011 at around 9:00 a.m. PX 2. He reported a tingling sensation to the right fourth and fifth finger. PX 2. The evaluating physician ordered a CT of the cervical spine, which revealed no acute injury to the cervical spine and mild degenerative changes. PX 2. Petitioner was diagnosed with right finger numbness and prescribed Tramadol. PX 2. He was further instructed to follow-up with his primary care physician. PX 2.

That same day, Petitioner presented to his primary care physician, Dr. Doris Williams. PX 1. Petitioner testified he presented to Dr. Williams because he was in severe pain and was unable to tie his boots or bend over. Petitioner reported he had been knocked off a drilling rig. PX 1. He further reported increased pain in his neck, right shoulder, and arm and increased numbness in his fingers. He rated the pain in his arm as six out of ten. He reported a shock-like sensation in his right thumb the previous evening when trying to cut something and a similar sensation in his right hand when putting on his boots. PX 1. On physical examination, Dr. Williams noted increased discomfort with range of motion of the neck and increased discomfort with range of motion of the right shoulder and wrist. PX 1. Dr. Williams assessed an acute neck strain and acute right shoulder strain, and noted complaints of increased paresthesias to the fingers of the right hand and complaints of electrical shock-like sensation to the right thumb. PX 1. Dr. Williams prescribed Naproxen. PX 2. Dr. Williams further placed Petitioner off work. PX 1.

Petitioner returned to Dr. Williams on October 11, 2011. He reported continued neck, right shoulder and right arm pain and that rated as six to eight out of ten. He also reported increased pain in the ulnar elbow. PX 1. He reported no relief from Naproxen. PX 1. Further, he reported continued numbness in his right thumb. PX 1. On physical exam, Petitioner continued to exhibit discomfort with range of motion of the neck and right shoulder. PX 1. At this time, Dr. Williams prescribed Ultram and referred Petitioner to physical therapy. PX 1.

On October 19, 2011, Petitioner presented to Premiere Physical Therapy for evaluation and treatment. PX 3. He continued to receive physical therapy through April 4, 2012. PX 3.

Petitioner returned to Dr. Williams on October 25, 2011, reporting that physical therapy was not helping. He further reported that his complaints were worse. PX 1. Dr. Williams noted decreased range of motion of the neck and increased discomfort of with range of motion of the right shoulder. PX 1. Dr. Williams recommended Petitioner undergo an EMG/NCS. PX 1. Dr. Williams continued to restrict Petitioner from work. PX 1.

On October 31, 2011, Petitioner underwent an EMG/NCS with Dr. Edward Trudeau. PX 4. The EMG/NCS revealed moderately severe right C6 radiculopathy and mild to moderate median neuropathy at the right wrist. PX 4.

Petitioner returned to Dr. Williams on November 4, 2011. PX 1. He complained of continued pain in the neck rated at an eight out of ten, and reported it hurt to turn his head. PX 1. He also continued to have pain in the right deltoid muscle, right arm, and right scapular area, as well as continued numbness in the right thumb. PX 1. Plaintiff's physical exam was largely unchanged. PX 1. Dr. Williams recommended an MRI of the cervical spine, and prescribed Indocin and Flexeril. PX 1. Dr. Williams continued Petitioner's off work restrictions. PX 1.

Petitioner underwent an MRI of his cervical spine on November 9, 2011 at Springfield MRI and Imaging Center. PX 5. The MRI revealed multilevel cervical spine findings, but no significant spinal stenosis. PX 5. Subsequently, Dr. Williams referred Petitioner for a surgical evaluation. PX 1.

On December 7, 2011, Petitioner presented to Dr. Timothy VanFleet, an orthopedic spine surgeon, for evaluation. Petitioner reported persistent pain in the back of the neck and into the right wrist since his September 28, 2011 accident. PX 6. He reported the neck pain was radiating in to the shoulder, and that he had numbness into his thumb, index, and middle finders. PX 6. On physical examination, Dr. VanFleet noted pain with overhead abduction of the right shoulder. PX 6. Dr. VanFleet further noted a positive Tinel's sign at the right wrist and positive impingement sign at the right shoulder. PX 6. Dr. VanFleet reviewed Petitioner's November 9, 2011 MRI, noting no evidence of disc prolapse or focal neurologic compression. PX 6. Dr. VanFleet diagnosed cervical whiplash and right carpal tunnel syndrome. PX 6. Dr. VanFleet recommended Petitioner continue physical therapy. He further recommended continued use of Indocin and prescribed Tramadol. PX 6. Dr. VanFleet further prescribed a cock-up wrist splint for the right wrist. PX 6. Petitioner was instructed to return for follow-up in six weeks. PX 6.

Petitioner returned to Dr. Williams on December 9, 2011, reporting continued complaints in the neck and tingling in the tips of his fingers and thumb. PX 1. On physical examination, Dr. Williams noted discomfort on palpation and range of motion of the neck, persistent complaints of tinging in the right wrist with percussion of the volar wrist, and increased discomfort on range of motion of the right shoulder. PX 1. Dr. Williams added Gabapentin to Petitioner's prescription regime. PX 1.

On January 8, 2012, Petitioner returned to Dr. VanFleet for follow-up evaluation. PX 6. He reported physical therapy had helped his complaints, but that he continued to have a "pinch" across the posterior aspect of his neck when he turned his neck rapidly. PX 6. He further complained of ongoing pain in the shoulder, forearm, and hand. PX 1. He felt his hand was swollen. PX 6. With regard to his cervical spine, Dr. VanFleet recommended the Petitioner continue home exercises, and found Petitioner to be at maximum medical improvement. PX 6. With regards to the right arm, Dr. VanFleet referred Petitioner for evaluation of Dr. Christopher Maender. PX 6.

Petitioner presented to Dr. Maender, an orthopedic surgeon, on January 20, 2012. Petitioner reported his neck was not 100% better at that time. PX 6. However, Petitioner indicated most of his pain was along the lateral side of the right arm. PX 6. He reported it hurt to push right over the lateral mid brachium. PX 6. He reported his pain radiated down towards the elbow and sometimes extended into the forearm, wrist, and hand. PX 6. He further reported numbness in all of his fingertips on the right side, worse in the index and middle fingers, and that his thumb was completely numb. PX 6. He further reported numbness along his thenar pad, and posterior and posteromedial elbow pain. PX 6.

On physical examination, Dr. Maender noted decreased sensation subjectively to all of Petitioner's fingers, thumb more than index and middle, which were more decreased than the small and ring fingers. PX 6. Palpation of the dorsal aspect of the wrist caused severe sharp pain on the palmar aspect. PX 6. Palpation over the volar wrist proximal to the proximal flexion crease gave Petitioner severe sharp pains that radiated up towards the neck. PX 6. Petitioner was tender globally around the elbow and was exquisitely tender over the lateral side of the arm in the area of the deltoid insertion. PX 6. Petitioner exhibited limited flexion of 90 degrees on the right, compared with 120 degrees on the left. PX 6. External rotation was 70 degrees on the right compared with 80 degrees on the left. PX 6. Internal rotation as to L4 on the right compared with T12 on the left. PX 6. Petitioner had no strength to internal and external rotation resistance, and such tests gave him severe pain ion the lateral side of his brachium. He further had no strength with forward flexion, and exhibited severe pain all the way down his arm and mostly along the lateral brachium. PX 6. Dr. Maender was unable to perform empty can, Neer, or Hawkins testing secondary to Petitioner's pain. PX 6.

Dr. Maender recommended Petitioner undergo a repeat EMG to evaluate for possible nerve compressions. PX 6. Dr. Maender further recommended additional physical therapy. PX 6. Dr. Maender further placed restrictions of no lifting greater than 10 pounds, no climbing of ladders, and no use of the right arm above shoulder height. PX 6.

On January 26, 2012, Petitioner underwent an EMG with Dr. Paul Smucker. PX 6. The EMG revealed mild-to-moderate right median sensory neuropathy at the wrist, demyelinative-type, consistent with a focal entrapment at the carpal tunnel. PX 6.

Petitioner returned to Dr. Maender on February 27, 2012. PX 6. Dr. Maender reviewed Dr. Smucker's report, and noted it showed right sided carpal tunnel syndrome. PX 6. Petitioner reported having no numbness and tingling symptoms in the right arm prior to his work accident. PX 6. Dr. Maender further noted Petitioner had received no relief with therapy regarding his pain, although his strength had increased some. PX 6.

On examination, Dr. Maender noted improved range of motion, but that such movement caused Petitioner pain. PX 6. He further noted good strength resistance of the rotator cuff. PX 6. Dr. Maender noted pain to palpation over the lateral brachium at the mid humerus level, which caused excruciating pain. PX 6. Petitioner further continued to have some soreness along the posterolateral elbow at the glenohumeral joint. PX 6. Petitioner further exhibited pain along his paraspinal and parascapular muscles. PX 6. Dr. Maender noted a positive Tinel on the right and an equivocal Phalen and reverse Phalen. PX 6. Petitioner had decreased sensation to the tip of the thumb, but no Tinel over the digital nerves. PX 6. Petitioner's strength was overall better. PX 6.

Dr. Maender diagnosed Petitioner with a contusion to the right lateral arm with right arm pain, but was concerned with potential shoulder pathology. PX 6. Dr. Maender recommended Petitioner undergo an MRI of the right shoulder. PX 6.

Furthermore, Dr. Maender diagnosed Petitioner with carpal tunnel syndrome, as confirmed by the EMG study. PX 6. Dr. Maender noted "[w]ith that large injury, he may have bruised a nerve, where a carpal tunnel release may be an option to help him." PX 6. However, Dr. Maender recommended obtaining an MRI and re-

evaluating prior to scheduling a carpal tunnel release. PX 6. Further, Dr. Maender continued Petitioner's work restrictions. PX 6.

On February 29, 2012, Petitioner underwent an MRI of the right shoulder without contrast. The MRI showed a probable posterior/superior glenoid labrum tear with small paralabral cyst, partial bursal surface tear of the distal supraspinatus tendon with fluid in the subacromial-subdeltoid bursa suggesting bursitis and type II acromion with mild hypertrophic degenerative change at the right AC joint. PX 9.

Petitioner returned to Dr. Maender on March 12, 2012. Dr. Maender reviewed Petitioner's February 29, 2017 MRI, noting a superior labral tear with a small accompanying cyst. PX 6. However, Dr. Maender noted the MRI did not include the area of the deltoid insertion, which was the area Petitioner reported the most significant pain. PX 6. Dr. Maender noted "[t]he area over his lateral humerus, I think that is most likely a direct blow/contusion to the area. I do not think there will be much to do to is, but to check his deltoid." PX 6. Dr. Maender recommended an MRI of the proximal humerus to rule out anything significant in that area. PX 6. Dr. Maender stated that if the new MRI was benign, he would recommend a carpal tunnel release. PX 6. Further, Dr. Maender stated:

> In regards to work relatedness with his carpal tunnel syndrome, he may have had it preexisting, and I do not have a way to know that. I think with that large torqueing incident, and with the most likely direct blow to the area, that will increase his numbness and tingling, and I think it is reasonable that his carpal tunnel has been worsened by that direct blow.

PX 6

Further, with regards to the shoulder, Dr. Maender opined "[i]n regards to his shoulder, he has a SLAP tear. That large traction and torsion could create a SLAP-type lesion." PX 6. Dr. Maender further recommended Petitioner undergo a shoulder arthroscopy. PX 6. Dr. Maender continued Petitioner's work restrictions. PX 6.

On March 15, 2012, the Petitioner underwent an MRI of the right upper extremity. PX 10. The results of this MRI were normal.

On April 2, 2012, Petitioner was sent for an Independent medical evaluation with Dr. Mitchell Rotman. The examination took approximately 35 to 40 minutes. Petitioner testified that during the examination, Dr. Rotman put one hand on the back of his neck and "ripped" his shoulder back. Petitioner testified this caused him severe pain, which he reported to Dr. Rotman.

After Dr. Rotman issued his report, Petitioner's case was denied by Respondent. From that point forward, Petitioner testified his medical treatment was paid by Illinois Public Aid. Further, his temporary total disability benefits were suspended.

On April 4, 2012, Petitioner returned to Dr. Williams. Petitioner reported increased pain in the lower posterior neck, right shoulder, and right shoulder blade. PX 1. He further reported continued numbness and tingling in the right hand. PX 1. He reported his hand was swelling all the time. PX 1. He further reported "he is back to square one" and that he did not fall asleep until approximately 4:30 a.m. the night before. PX 1. On exam Dr. Williams noted increased discomfort on range of motion of neck and right shoulder, as well as trigger point discomfort and reproduced pain on palpation of the right scapula. PX 1. Dr. Williams prescribed Vicodin and refilled Petitioner's prescription for Gabapentin. PX 1. Further, Dr. Williams prescribed physical therapy. PX 1.

Petitioner returned to Dr. Maender on April 6, 2012. Petitioner noted increase pain in his neck and the area of the medial scapula since meeting with Dr. Rotman. PX 6. He further reported increased ulnar-sided wrist

pain. PX6. Petitioner reported no change in his hand and shoulder complaints. PX 6. On examination, Dr. Maender noted positive Tinel's, Phalen's, and revers Phalen's over the carpal tunnel. PX 6. He further noted tenderness over the lateral side of the humerus. PX 6. Dr. Maender further noted Petitioner's neck appeared very stiff. PX 6. Dr. Maender continued to recommend surgical intervention for Petitioner's carpal tunnel syndrome and SLAP tear. PX 6. Petitioner's work restrictions were continued. PX 6.

In April 2012, Petitioner changed primary care physicians from Dr. Williams to Dr. Michael Murphy at Capitol Healthcare. Petitioner testified that he Dr. Williams moved her practice out of state, which required him to obtain a new primary care provider. Petitioner initially presented to Dr. Murphy on April 19, 2012. He reported right arm and shoulder pain onset six to seven months prior due to a fall at work. PX 11. Petitioner reported the only pain medication he was taking at that time as hydrocodone-acetaminophen. PX 11. On examination, Dr. Murphy noted tenderness and pain with range of motion of the right shoulder. PX 11. Dr. Murphy further noted a positive Tinel's sign in the right hand. PX 11. Dr. Murphy assessed radiculitis of the arm, acetabular labrum tear, and carpal tunnel syndrome of the right wrist. PX 11. Dr. Murphy recommended a repeat EMG and referred Petitioner for a neurological evaluation. PX 11.

On May 7, 2012, Petitioner underwent an EMG/NCS with Dr. Trudeau. PX 12. The EMG/NCS revealed moderately severe to severe right C6 radiculopathy and moderately severe median neuropathy at the right wrist. PX 12.

Petitioner presented to Dr. Margaret MacGregor, a neurosurgeon, on May 7, 2012. Petitioner reported numbness in the right thumb, tingling in the fingers of his right hand, and an aching, burning feeling from the right biceps up to the right shoulder. PX 13. He further reported a pinching feeling in his neck and to the right of his neck. PX 13. Dr. MacGregor reviewed Petitioners November 9, 2011 MRI of the cervical spine, noting C2-3 posterior osteophytes, a probable small central to left paracentral disc herniation present which mildly flattens the thecal sac, C3-4 posterior osteophytes and small disc bulge, C5-6 and C6-7 small central disc herniation with no spinal stenosis and C7-T1 small posterior osteophytes and disc bulge. PX 13. She further reviewed Petitioner's October 31, 2011 EMG, which noted right C6 radiculopathy and median neuropathy of the right wrist. PX 13. Dr. MacGregor assessed cervical disc degeneration. PX 13. She recommended Petitioner undergo an epidural steroid injection to the neck. PX 13. Dr. MacGregor further prescribed a Medrol Dose pack and ordered a cervical spinal series. PX 13.

Petitioner underwent x-rays of his cervical spine on May 7, 2012, which showed mild degenerative changes of C4 through C7 with no acute abnormalities. PX 13.

Petitioner returned to Dr. Maender on June 15, 2012. He reported aching in his neck and wrist, as well as burning in his shoulder and numbness in his hand. PX 6. Petitioner's physical exam was unchanged. PX 6. Dr. Maender continued to recommend surgery for right carpal tunnel syndrome and SLAP tear. PX 6. Petitioner testified that he stopped seeing Dr. Maender after the June 15, 2012 office visit because his case was being denied by workers' compensation and Dr. Maender's office did not accept his personal health insurance.

Petitioner returned to Dr. MacGregor on June 21, 2012. PX 13. Petitioner reported constant pain in the right side of the neck and right shoulder, and numbness from his elbow to his wrist. PX 13. Dr. MacGregor assessed cervical spondylosis and indicated Petitioner may benefit from an anterior cervical discectomy and fusion. PX 13.

On April 7, 2014, Petitioner returned to Dr. MacGregor's office and was evaluated by her nurse practitioner, Elvia Washington. PX 13. Petitioner complained of ongoing pain in the neck and right shoulder and continued numbness down the right arm and tingling in the fingers. PX 13. Examination showed limited range of motion with the upper extremities. PX 13. Ms. Washington noted Petitioner was in "intense

discomfort." And that he repositioned himself several times on the exam bench. PX 13. Petitioner was assess with cervical radiculopathy at C6 and cervical spondylosis. PX 13. Ms. Washington prescribed a Medrol Dosepak and ordered an MRI of the cervical spine. PX 13.

On April 9, 2014, Petitioner presented to Dr. Michael Sheedy, to establish as a new primary care patient. PX 14. Petitioner reported a history of work injury and complained of right wrist pain, right posterior neck and right shoulder pain. PX 14. He further reported upper extremity stiffness, decreased range of motion, and numbness and tingling to the right thumb. PX 14. Physical examination revealed tenderness to the right posteriolateral neck and right shoulder, decreased range of motion in all neck planes and decreased abduction of the right shoulder. PX 14. Dr. Sheedy recommended an MRI of the cervical spine and that Petitioner follow-up with Dr. Maender. PX 14.

Petitioner underwent an MRI of his cervical spine on April 15, 2014. PX 15. The MRI revealed some minimal focal central disc protrusions at C2-3, C4-5, C5-6, and C6-7, but was otherwise normal. PX 15.

On April 15, 2014, Petitioner returned to Dr. Maender for re-evaluation of his shoulder and wrist. PX 6. Petitioner reported pain in the shoulder and scapula. PX 6. Petitioner reported his pain remained the same as the last time he had seen Dr. Maender. PX 6. On examination, Dr. Maender noted limited range of motion to the neck with discomfort upon range of motion testing. PX 6. Right shoulder flexion was limited at 150 degrees and external rotation limited to 60 degrees. Dr. Maender noted a positive empty can test. PX 6. Further, Dr. Maender noted pain to palpation at the AC joint and scapular spine. PX 6. Dr. Maender recommended an MRI arthrogram of the right shoulder and a bilateral EMG/NCV of his upper extremities. PX 6.

On April 24, 2014, Petitioner underwent an MRI arthrogram of the right shoulder at St. John's Hospital. PX 16. The arthrogram revealed a small area of increased signal in the supraspinatus tendon which might indicate a focal intrasubstance partial thickness tear or a focal area of tendinitis or tendinosis. PX 16. Further, the study showed a more prominent abnormal signal in the subscapularis tendon suggesting tendinitis, tendinosis or partial intrasubstance tear of the subscapularis tendon. PX 16. The anterior cartilaginous glenoid labrum and an abnormal appearance with mixed increased signal suggesting partial tear and/or degeneration of the anterior cartilaginous glenoid labrum. PX 16. Further, there was a subtle abnormality near the cartilaginous labral bony junction in the posterior labrum without contrast extension into the defect that raised concern of a previous partial tear at the cartilaginous labral bony labral junction and the posterior labrum. PX 16.

Petitioner underwent an EMG with Dr. Smucker on May 1, 2014. Unfortunately, the examination as terminated shortly after start due to Petitioner's intolerance of the procedure. PX 17. However, the limited findings obtained were suggestive of right median neuropathy at the wrist and possible mild ulnar sensory neuropathy at the right wrist/Guyon's canal. PX 17.

Petitioner returned to Dr. Maender on May 13, 2014. Dr. Maender reviewed the MRI, noting some tendonitis of the supraspinatus tendon and subscapularis, as well as degenerative tears to the labrum. PX 6. Dr. Maender did not recommend shoulder surgery at that time. PX 6. He did recommend continued observation of Petitioner's right carpal tunnel syndrome. PX 6.

On May 19, 2014, Petitioner returned to Dr. MacGregor for follow-up. PX 13. Dr. MacGregor recommended Petitioner be evaluated for an epidural steroid injection with Dr. Narla. PX 13. Further, Dr. MacGregor recommended Petitioner undergo aquatherapy and prescribed Toradol. PX 13.

On June 10, 2014, Petitioner underwent a C6-7 right-sided cervical epidural steroid injection with Dr. Koteswara Narla. PX 18. PX 18. Petitioner testified that he received no relief from the injection.

Petitioner returned to Dr. MacGregor on July 17, 2014, at which time she recommended Petitioner undergo an EMG. PX 13. Dr. MacGregor further reiterated her recommendation for aquatherapy. PX 13.

Petitioner presented to St. John's Therapy Care on July 29, 2014 for aquatherapy. PX 19. Petitioner continued to undergo aquatherapy until September 2, 2014. Petitioner testified that the aquatherapy was soothing and relaxing, but that he continued to have pain.

On July 29, 2014 Petitioner returned to Dr. Maender. He reported ongoing numbness and tingling in the right hand. PX 6. He reported this was worse at night and that he would wake up with numbness throughout his arm. PX 6. On examination, Petitioner had limited range of motion to the right shoulder with flexion and external rotation. PX 6. Further, Petitioner had pain to palpation at the rhomboids and pain along the medial scapular border and at the mid-clavicle. PX 6. Dr. Maender noted a positive Tinel's at the right carpal and cubital tunnel. PX 6. Dr. Maender noted "with his areas of pain, I think he will need to get neck situated prior to considering other interventions." PX 6. Dr. Maender recommended continued strengthening and range of motion exercises for the shoulder. PX 6.

On August 1, 2014, Petitioner underwent an EMG/NCS of the right upper extremity with Dr. David Gelber. PX 20. The EMG revealed moderately severe right carpal tunnel syndrome, with no evidence of ulnar or radial neuropathy and no evidence of peripheral neuropathy, brachial plexopathy or cervical radiculopathy. PX 20.

Petitioner returned to Dr. MacGregor on August 25, 2014. At that time, Dr. MacGregor reviewed Petitioner's MRI and EMG with him. PX 13. Dr. MacGregor noted the MRI showed no nerve pinching, and noted that she was unable to determine the source of his irritation, and therefore would not be able to operate on him. PX 13. Dr. MacGregor recommended a CT Myelogram of the cervical spine and a left sided EMG study to rule out any further pathology. PX 13.

Petitioner underwent a CT Myelogram of the cervical spine on September 12, 2014. PX 21. The CT Myelogram revealed no significant canal stenosis or neural foraminal narrowing. PX 21.

On September 16, 2014, Petitioner underwent an EMG/NCS for his left upper extremity with Dr. Gelber. PX 23. The EMG revealed mild left carpal tunnel syndrome. PX 23.

Petitioner last saw Dr. MacGregor on October 27, 2014. PX 13. Petitioner reported constant, ongoing neck pain. PX 13. Petitioner rated his pain as a four out of ten. PX 13. Dr. MacGregor reviewed Petitioner's additional studies and was unable to find a surgical option from a neurosurgery standpoint. PX 13. Dr. MacGregor recommended Petitioner be re-evaluated from an orthopedic standpoint for his shoulder. PX 13.

On November 26, 2014, Petitioner presented to Dr. Mark Greatting, an orthopedic surgeon, for evaluation of his right shoulder and arm, upon referral from Dr. Sheedy. PX 24. Petitioner reported his history of accident and that he had received treatment with several other doctors and undergone several diagnostic studies. PX 24. ~~Dr. Greatting noted Petitioner had undergone an EMG/NCS of his right side on August 1, 2014, which showed~~ moderately severe right carpal tunnel syndrome. PX 24. Dr. Greatting further noted Petitioner had an MRI arthrogram of his right shoulder on April 24, 2014 which showed a possible intrasubstance partial-thickness tear or tendinitis of the supraspinatus and subscapularis tendon, a possible anterior labral abnormality, anterior capsule abnormality and a possible posterior labral abnormality. PX 24. On physical examination, Dr. Greatting noted some tenderness diffusely over the posterior scapular area. PX 24, Dr. Greatting further noted Petitioner was significantly tender over his AC joint and anterior shoulder region. PX 24. Dr. Greatting noted limited internal rotation of the right shoulder and a positive Hawkins impingement test. PX 24. Petitioner further had positive Tinel's and compression tests over the right carpal tunnel. PX 24. Dr. Greatting diagnosed Petitioner with chronic right shoulder pain, which he opined appeared to be related to AC joint arthritis and rotator cuff

tendinitis. PX 24. Further, Dr. Greatting noted petitioner had history and exam findings consistent with carpal tunnel syndrome. PX 24. Dr. Greatting recommended Petitioner undergo a right shoulder arthroscopy with subacromial decompression and distal clavicle excision. PX 24.

On February 10, 2015, Petitioner underwent a right shoulder arthroscopy with subacromial decompression and distal clavicle excision and a right carpal tunnel release with Dr. Greatting. PX 26. On arthroscopic evaluation of the shoulder, Dr. Greatting noted a large amount of chronically appearing thickened bursal tissue. PX 26. Further, Dr. Greatting noted a prominence or curvature with some osteophyte formation on the anterior inferior acromion. PX 26. There were marked arthritic changes in the AC joint with inferior protruding osteophytes from the distal clavicle. PX 26. Petitioner testified he was placed off work by Dr. Greatting post-surgically.

Petitioner returned to Dr. Greatting for surgical follow-up on February 25, 2015. Dr. Greatting continued to keep Petitioner off work at this time. PX 24.

Petitioner began post-surgical physical therapy at Springfield Clinic for his right shoulder and arm on March 2, 2015. PX 27. He continued to receive physical therapy until June 17, 2015.

Petitioner returned to Dr. Greatting on March 30, 2015. PX 24. He reported that the numbness and tingling in his hand had resolved, and that his shoulder pain had significantly improved, but not resolved entirely. PX 24. He reported therapy was helping. PX 24. On examination, Petitioner was able to forward flex and abduct to greater than 130 degrees with some pain and internal rotation was mildly limited. PX 24. Tinel's sign was negative over the carpal tunnel. PX 24. Dr. Greatting recommended continued physical therapy and kept Petitioner off work. PX 24.

On May 7, 2015, Petitioner returned for final post-surgical follow-up with Dr. Greatting. PX 24. Petitioner reported the numbness in his hand had resolved and the pain in his shoulder had markedly improved. PX 24. He reported good motion and strength in the shoulder. PX 24. Dr. Greatting noted "[h]e has done well following his surgery concerning his right arm and the surgical treatment he received." PX 24. Dr. Greatting released Petitioner from care without restrictions. PX 24.

On August 27, 2015, Petitioner was evaluated by Jennifer Nichelson, a neurology physician assistant. PX 28. Petitioner reported ongoing neck pain due to an injury four years prior. PX 28. Petitioner reported pain in his neck and stiffness in his neck and upper back. PX 28. Ms. Nichelson did not have any additional recommendations for Petitioner with regards to his neck, as he had been fully evaluated by Dr. MacGregor. PX 28.

Dr. MacGregor testified via her evidence deposition, taken on August 21, 2013. PX 29. Of note, Dr. MacGregor's deposition was taken at a time when she had only seen the Petitioner on two occasions, and therefore does not include any testimony regarding treatment that occurred after June 21, 2012. PX 29. Dr. MacGregor testified that she had reviewed the MRI images taken of Petitioner's cervical spine and did not disagree with the radiologist's findings. PX 29, p. 8. Particularly, she noted a small disc bulge at C5-6 and C6-7. PX 29, p. 9. Dr. MacGregor agreed that the November 9, 2011 did not identify any cord compression, but also noted that she has had trouble in the past with the quality of films from Springfield Imaging Center. PX 29, p. 15-16. Further, Dr. MacGregor testified she had reviewed the EMG taken on October 31, 2011, and agreed that it showed moderately severe right C6 radiculopathy, as well as mild to moderate median neuropathy at the right wrist. PX 29, p. 9. Dr. MacGregor testified that Mr. Pierce's subjective complaints upon examination on May 7, 2012 were consistent with right C6 radiculopathy. PX 29, p. 9. Dr. MacGregor testified that she was not aware that Petitioner had undergone an EMG with Dr. Smucker which showed no cervical radiculopathy, but indicated that often the EMG results vary based on the person performing the test, and that she would not be surprised if

another doctor performing the EMG did not find cervical radiculopathy. PX 29, p. 17. She noted that the bigger concern was that Petitioner had undergone two EMG's with Dr. Trudeau which showed progressing cervical radiculopathy. PX 29, p. 18.

Dr. MacGregor testified that the disc herniation at C5-6 described in the MRI of November 9, 2011 could possibly be the cause of the C6 radiculopathy referred to in Dr. Trudeau's October 31, 2011 EMG study. PX 29, p. 10. She testified that the C6 nerve root exits the spine at the C5-6 level in a person of normal anatomy. PX 29, p. 10. She further testified that direct compression on the exiting nerve root is generally the cause of radiculopathy. PX 29, p. 10. She further testified that even absent a large herniation, Petitioner could have a direct compression that cause causing C6 radiculopathy. PX 29, p. 11.

Dr. MacGregor opined that the fall that occurred on September 28, 2011 could have caused a disc herniation that caused compression of the C6 nerve. PX 29, p. 11. Further, Dr. MacGregor opined that if Petitioner had a pre-existing degenerative disc condition at C5-6, it could have been asymptomatic prior to the fall, and the fall could have rendered the condition symptomatic. PX 29, p. 12. Further, Dr. MacGregor opined the fall could cause a permanent aggravation to a pre-existing condition. PX 29, p.12.

Dr. Greatting also testified via his evidence deposition, taken on August 29, 2016. PX 30. Dr. Greatting is a board certified orthopedic surgeon with added qualifications in surgery of the hand. PX 30, p. 6. Dr. Greatting's practice is limited to treatment of the upper extremities. PX 30, p. 7. Dr. Greatting testified that upon initially evaluating Petitioner, he diagnosed symptomatic AC joint arthritis, rotator cuff tendinitis and right carpal tunnel syndrome. PX 30, p. 13. He testified that these diagnoses accounted for the pain in Petitioner's shoulder area and the numbness in his hand. PX 30, p. 13. He further testified that Petitioner had some neck and scapular pain that was not related to those diagnoses. PX 30, p. 13. Dr. Greatting testified he recommended arthroscopic surgery of the shoulder and a carpal tunnel release. PX 30, p. 13. He further testified that both surgeries were reasonable and necessary given his review of the history and diagnostic studies, and his physical examination. PX 30, p. 15.

Dr. Greatting testified that during surgery, which he performed on February 10, 2015, he noted a large amount of chronically-appearing thickened bursal tissue and significant AC joint arthritis. PX 30, p. 16. He testified he found no traumatic findings, such as a tear. PX 30, p. 16. He testified that a patient can have AC joint arthritis that's asymptomatic. PX 30, p. 16. He testified that Petitioner's accident, as reported in the medical records of Dr. MacGregor, which he had an opportunity to review, caused Petitioner to develop rotator cuff tendinitis, bursitis, and aggravated a preexisting AC joint arthritis. PX 30, pp. 16-17. Dr. Greatting testified that tendinitis or bursitis is an inflammation of the rotator cuff area. PX 30, p. 17.

Further, Dr. Greatting was posed a hypothetical based on information provided to Dr. Mitchel Rotman during his Section 12 evaluation, which included that Petitioner had been thrown off of a drilling rig, was pushed backwards off the rig, that he was hit in the waist by a gate, was somehow pushed backwards, wound up upside down in the air, fell back, hit his right shoulder blade and neck, landed and rolled. PX 30, p. 17. Dr. Greatting testified that he believed if Petitioner had sustained an accident with those facts, that the accident would have caused the bursitis and tendinitis of the rotator cuff and aggravated the underlying degenerative conditions. PX 30, p. 18.

Dr. Greatting agreed that his causation opinion was based on a presumption that Petitioner had an onset of right shoulder complaints within a month to six weeks of the accident. PX 30, pp. 23-24. Dr. Greatting was subsequently directed to an MRI of the cervical spine taken November 9, 2011, and noted that the history in the reported included right shoulder pain. PX 30, p. 28. Dr. Greatting noted that this report was generated approximately six weeks after the accident, and was consistent with the time frame of developing shoulder pain following the reported trauma. PX 30, pp. 28-29.

On April 2, 2012, Petitioner underwent an IME with Dr. Mitchell Rotman at the request of the Respondent. Dr. Rotman testified via his evidence deposition, taken on January 16, 2014. RX 2. Dr. Rotman testified he is an orthopedic surgeon with a subspecialty in upper extremity surgery. RX 2, p. 5. Dr. Rotman does not provided treatment of the spine, is not an orthopedic spine surgeon, and is not trained in neurosurgery. RX 2, p. 24. Dr. Rotman testified that Petitioner reported an injury on September 29, 2011 where he was thrown off of a drilling rig at work. RX 2, p. 10. He was pushed backward off the rig after being hit in the waist by a gate. RX 2, p. 10. He ended up upside down in the air and fell back, hitting his right shoulder blade and neck. RX 2, p. 10. Dr. Rotman opined that Petitioner's shoulder exam was negative for any type of rotator cuff problem or shoulder joint problem, and he had no evidence of cervical radiculopathy. RX 2, p. 16. He testified he Petitioner did have findings consistent with carpal tunnel syndrome on the right. RX 2, p. 16.

Dr. Rotman testified "I couldn't find any particular problems with the neck or shoulder at the time of my evaluation. I suspected that he had a strain of the shoulder blade or something like that at the time of his injury; but when I saw him, I couldn't relate his pain complaints to any particular physical problem." RX 2, p. 17. Dr. Rotman was unable to correlate Petitioner's carpal tunnel syndrome to his accident, as there was no evidence of wrist trauma or "evidence of acute carpal tunnel syndrome." RX 2, p. 18. Dr. Rotman testified he believed Petitioner had reached MMI and did not require work restrictions. RX 2, p. 19.

Additionally, Dr. Rotman performed an impairment rating, which he testified to in his deposition. Without any explanation as to how he came to the rating, Dr. Rotman found that Petitioner had zero percent impairment of the shoulder and zero percent impairment of the cervical spine. RX 2, pp. 20-21.

The Petitioner testified that he continues to have pain in his neck and shoulder. He testified that his neck pain is located at that base of the neck on the right side. He described the pain as knotting, tight, and uncomfortable. The pain is localized to the base of his neck and does not radiate. He testified that he does not have neck pain all of the time, but does have pain daily. Nothing alleviates his pain. His pain is increased by bending over, attempting to lift, or performing any strenuous activity.

With regard to his shoulder, Petitioner testified he continued to have pain located on the right side a little behind the shoulder area. He indicated the shoulder was more uncomfortable than the neck and that it was constant. Petitioner testified the pain radiates into the deltoid area. He testified that he is unable to perform hard labor due to his shoulder pain. He further testified that he has pain with mowing with his self-propelled push mower. Further, his pain wakes him up at night.

Petitioner testified that his carpal tunnel release was fairly successful, and his hand does not bother him much anymore.

Despite ongoing pain in his neck and shoulder, Petitioner testified he does not take pain medication. He testified that he does not want "to get hooked on pain pills." He explained that he had avoided taking any pain medication out of fear he would become addicted.

Petitioner testified he has a bicycle shop at his home, which he uses to repair and restore old bicycles. He testified that bicycle repair and restoration is a hobby, and that he does not sell the bicycles but rather collects them. He testified he performs changing nuts and bolts, repainting, and polishing. He does not lift the bicycles or work overhead. He performs repairs while sitting in a chair. Petitioner estimated he had repaired approximately 40 bikes over the past few years.

Further, Petitioner currently performs all household chores, as his wife had passed approximately a year before Arbitration. He testified he does some flower gardening, to upkeep his wife's gardens after her passing. He also testified he mows his own lawn with a self-propelled push mower, but that his home is on a small lot.

CONCLUSIONS OF LAW

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

The Petitioner is alleging essentially three areas where he was injured which were causally related to his accident. They are the right wrist for which the diagnosis was carpal tunnel syndrome, the right shoulder/upper arm for which there were two diagnoses which will be discussed below and the cervical spine. The Arbitrator considers each injury separately.

Petitioner alleges his right carpal tunnel syndrome has a causal relationship to the accident. The Arbitrator disagrees. At trial, Petitioner testified he was hit by a gate and flipped of a platform backwards and thereafter landed on his neck, right shoulder and right hand. Petitioner's testimony of landing on his right hand is not consistent with the accident history he provided to his treaters. The St. John's Hospital ER record from September 29, 2011, documented Petitioner gave only a history of landing on his right arm. Dr. MacGregor's record from May 7, 2012, documented Petitioner reported he hit his neck and right shoulder in his work accident. Dr. MacGregor reiterated this history during her deposition. Dr. Greatting had the same accident history as Dr. MacGregor. The histories given to Dr. VanFleet and Dr. Maender do not mention Petitioner reporting he had landed on his right wrist.

The Arbitrator finds the opinions of Dr. Greatting and Dr. Rotman are persuasive as to the lack of causal relationship of Petitioner's right carpal tunnel syndrome. Dr. Greatting testified the accident did not cause of aggravate the carpal tunnel syndrome in the right hand. Dr. Greatting testified Petitioner did not have a history of trauma that could cause or aggravate carpal tunnel syndrome. Dr. Rotman testified Petitioner had an idiopathic right carpal tunnel syndrome and noted Petitioner had a prior carpal tunnel on the opposite side before the accident. Dr. Rotman also testified there was no evidence of wrist trauma, wrist fractures, wrist dislocations or hand swelling noted in the medical evidence and therefore no evidence of acute carpal tunnel syndrome.

Dr. Maender's records reflect he believed Petitioner's right carpal tunnel syndrome was related to the accident. However, Dr. Maender's records do not indicate the basis of his opinion. There is no medical evidence of any trauma, abrasions, swelling, fractures or dislocations which would support Petitioner had an acute trauma to the right wrist. Therefore, the Arbitrator finds the opinions of Dr. Greatting and Dr. Rotman are more persuasive. The Arbitrator finds Petitioner failed to prove his right carpal tunnel syndrome has a causal relationship to an accident at work.

In order to consider causation on the right shoulder/upper arm, it is necessary to determine the conditions of ill being which were proven by the evidence. After several office exams and diagnostic testing, Dr. Maender diagnosed the Petitioner with a contusion to the lateral humerus. Throughout the time he treated with Dr. Maender, the Petitioner complained of sharp pain along the lateral aspect of the right arm in the area of the distal humerus. Dr. Maender also indicated that the injury was causally related to the accident. In is note of March 12, 2012, the doctor said that the right arm pain developed after the accident, which he described as producing a large torqueing force. He said the pain was most likely the result of a direct blow to the humerus. While the subsequent MRI of the area was negative, that did not rebut the diagnosis of a contusion. The Petitioner continued to complain of some pain in that part of his arm as he treated over the course of the next three years. He also indicated at trial that he had some pain in the area of the right deltoid. There is really no contrary evidence. The Arbitrator feels this condition is causally related to the accident.

The second upper arm injury is in the shoulder joint itself. It was diagnosed by various doctors based upon exams and diagnostic tests, but the ultimate diagnosis came during surgery on February 10, 2015. The operative report and Dr. Greatting's testimony establish that the Petitioner had an impingement syndrome in the right shoulder resulting from extensive bursitis and arthritis of the AC joint. Dr. Greatting testified that the accident was causally related to the development of the bursitis while also aggravating the arthritis. He further said that the fact that the Petitioner has a type 2 or sloping acromion may have made it more likely that an injury could develop after a trauma.

Respondent argues that there was no shoulder joint injury, relying primarily on the comments of Dr. Maender in his initial office note of January 12, 2012. During that initial visit, Dr. Maender did say that the Petitioner's exam was inconsistent inasmuch as he had pain throughout his entire arm. He used the term symptom magnification. However, after seeing the Petitioner for several more examinations and reviewing diagnostic tests, Dr. Maender changed his view. Despite acknowledging that the Petitioner's main symptoms were in the area of the humerus, the doctor said in his March 12, 2012 note that the large traction/torsion accident experienced by the Petitioner could have caused shoulder pathology, including a SLAP tear. The Arbitrator also believes the view might have been influenced by the physical therapy records from Premiere during that time frame where the Petitioner was noted to have provided a good effort in said therapy. (PX 3) Two years later on May 13, 2014, Dr. Maender, after reviewing an updated MRI,continued to diagnosis tendinitis and a labral tear. He did not think surgery was indicated at that time because he felt that the majority of the petitioner's symptoms were related to the cervical spine.

Clearly Dr. Greatting in surgery did not see any tears to the labrum or rotator cuff. However, he did find shoulder pathology which, again, he related to the Petitioner's accident.

Further, the treatment records from Dr. Williams and Premiere Physical Therapy from the accident date through mid April 2012 show the Petitioner with symptoms related to the shoulder and not just the small area on the lateral arm where he was contused. (See PX 1,3)

Respondent relies on Dr. Rotman's exam of April 2, 2012 to further support its claim that there was no shoulder injury. The Arbitrator does not find Dr. Rotman to be persuasive. He testified that the Petitioner exhibited symptom magnification during the exam, yet he said that the Petitioner's range of right shoulder motion was decreased when compared to the left. (RX 2 at 11,12) He later said that the Petitioner may have strained his shoulder blade in the accident. The Arbitrator gives more weight to the Petitioner's shoulder complaints noted by Dr. Williams and the physical therapist during approximately 17 visits the Petitioner made for treatment through April 6, 2012.

The Arbitrator finds the accident causally related to the Petitioner's humeral bone contusion and impingement syndrome referenced above.

With respect to the cervical spine, the Arbitrator notes that the Petitioner was treated extensively by Drs. Van Fleet and MacGregor, as well as undergoing multiple diagnostics. After reviewing an early MRI, Dr. van Fleet diagnosed a whiplash injury with no findings of any cervical disc herniations or stenosis. Two and a half years later, Dr. MacGregor reached essentially the same diagnosis. She reviewed MRI and myelogram/CT scans as well, noting no discs or stenosis. The Petitioner has complained of neck pain since the accident and the Arbitrator feels his complaints are consistent with the above diagnoses, which are in the nature of a cervical strain. Accordingly, the Arbitrator believes the condition to be causally related to the accident.

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

The Arbitrator's conclusions on causation are incorporated by reference. As such, the Respondent is ordered to pay all of the medical bills included in PX 31, except for those related to carpal tunnel, pursuant to the fee schedule.

Furthermore, a number of Petitioner's medical bills were paid by the Illinois Department of Public Health. A copy of IDPH's reimbursement lien is entered into evidence as Petitioner's Exhibit 32. The Respondent is ordered to reimburse IDPH directly for bills paid thereby, in accordance with the medical fee schedule.

Respondent shall receive a credit for all benefits previously paid to medical providers, as set forth in Respondent's Exhibit 8.

Issue K: Is Petitioner entitled to temporary total disability benefits?

After a review of the totality of the evidence, the Arbitrator finds that the Petitioner is entitled to temporary total disability benefits. The Petitioner was initially kept off work from the day after the accident, September 29, 2011 through June 16, 2012 by various providers. Upon coming under the care of Dr. Maender, Dr. Maender was the only physician restricting Petitioner from work. After Petitioner's June 15, 2012 appointment, Dr. Maender did not provide the Petitioner with ongoing restrictions or an off work slip. PX 6. Petitioner suspended treatment with Dr. Maender at that time as his health insurance was not accepted by Dr. Maender's group.

Petitioner was not given any further work restrictions until the date of his surgery with Dr. Greatting, February 10, 2015. Dr. Greatting proceeded to keep Petitioner off work until May 7, 2015, at which time Petitioner was given a full duty release.

The Arbitrator finds that Petitioner was reasonably kept off work for conditions relating to his September 28, 2011 accident during these two periods of time. Therefore, the Arbitrator awards, and the Respondent shall pay, temporary total disability benefits of $661.61 per week for a period of 49 and 5/7 weeks, commencing September 29, 2011 through June 16, 2012 and February 10, 2015 through May 7, 2015, as provided in Section 8(a) of the Act.

The Respondent has paid Petitioner temporary total disability benefits totaling $26,030.76. The Respondent shall receive a credit towards the award of temporary total disability benefits in that amount.

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

For accidents occurring after September 1, 2011, the Arbitrator must look to the five factor test in determining permanent partial disability. With regards to the first factor, an AMA impairment rating was performed by Dr. Rotman. However, the Arbitrator finds that the AMA impairment rating was rendered prior to the Petitioner reaching maximum medical improvement for any of his conditions. Therefore, the Arbitrator gives no weight to this factor.

As to the second factor, nature of the employment, Petitioner worked as a laborer for the Respondent changing drill bits on a drill used for boring 200 foot geothermal wells. This was strenuous, physical labor. Further, Petitioner had been a union laborer for 25 years prior to his accident, working in various types of physical labor. Petitioner has an eighth grade education, does not have a GED, and has only ever worked in physical labor. The Arbitrator gives greater weight to this factor.

With regards to the third factor, age, the Petitioner was 52 years old on the date of his accident, and is currently 60 years of age. Petitioner currently receives social security disability. The Arbitrator places less weight on this factor.

With regards to the fourth factor, future earning capacity, the Petitioner was returned to full duty work by Dr. Greatting after his shoulder and carpal tunnel surgeries. However, Petitioner has not returned to his employment with Respondent and currently receives social security disability benefits. The Arbitrator finds that Petitioner has not established a loss in future earning capacity, despite not returning to work. The Arbitrator places less weight on this factor.

Finally, with regards to the fifth factor, evidence of disability corroborated by treatment records, the Petitioner testified he continues to have pain in his neck and shoulder. He located the pain in his neck and the base of the neck on the right side. He described his pain as knotting, tight, and uncomfortable. He did not report any radiation of his pain. He testified that he has neck pain daily, and that it is increased by bending over, attempting to lift, or performing strenuous activity.

The Petitioner has had no treatment for his humerus contusion since he began treating with Dr. Greatting. As noted above, Dr. Maender objectively diagnosed the condition based upon the Petitioner's consistent complaints of pain over a specific location. With respect to the impingement syndrome, the Petitioner appears to have done well since his surgery. At his last therapy visit on March 26, 2015, he was found to have slight decreases in the range of motion for flexion, abduction and extension. His strength was measured at 4/5 and he was told to do home exercise. (PX 27) On May 7, 2015, Dr. Greatting noted good motion and strength. He released the Petitioner without any restrictions.

Dr. MacGregor released the Petitioner from cervical care on October 27, 2014. Her findings are noted above. His neck treatment since then consists of visits to Dr. Sheedy and Nichelson, neither of whom provided any objective findings.

The Arbitrator places greater weight on the fifth factor.

Taking the evidence and the five factors into consideration, the Arbitrator finds that Petitioner has sustained a 10% loss of the person as a whole for his injuries. Specifically, the Arbitrator values the upper arm/ shoulder injuries at 7.5 %, while the cervical injuries amount to 2.5 %.