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

Gustavo Dominguez-Zilli,

Petitioner,

vs.

NO: 11 WC 46725
12 WC 04491

Cintas,

Respondent.

16IWCC0364

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 54 year old employee of Respondent, who described his jobs. Petitioner was working for Respondent in September 2011 and at that time he had been there 14-15 years. Petitioner had been hired by Respondent in 1998 under the name Juan Fray Vasquez and he began using Gustavo Dominguez-Villi in 2005 (no longer under Vasquez). He changed the name he used because they told Petitioner they were going to

be checking documents and they were then giving Petitioner two weeks to take care of that. Petitioner testified that he came back with documents for Respondent; he did not recall what year, but that was when he started using the name Gustavo Dominguez-Villa and Respondent accepted Petitioner under that name and Petitioner had then continued working for Respondent until his accident. In September 2011 Petitioner testified that Respondent had him washing machines in the washing corridor. He had to program the bags in the computer and send each one to the washing machines. On the date of accident, **September 9, 2011-(11 WC 46725)**, Petitioner testified that the truck loaders did not show up and Mr. Navarrette, the boss at the time, told Petitioner to go and unload trucks with a co-worker. Petitioner indicated that normally there were 3-4 people when fully staffed. That day there was just Petitioner and a young guy unloading the trucks. Petitioner stated that day was unloading the trucks and they had to pick up a pile of clothes and when picking up the piles he got a very strong pain in his lower back. He had to pick up the clothes from the floor of the truck as it was all thrown all over on the floor. He had to pick up the clothes with his arms from the floor and put into a laundry bag and that was when he got the bad pain. His normal shift was t:00 to 10:00pm and the accident occurred about 8:00-9:00pm. Petitioner testified that he did not tell the supervisor that day as when he left work at 10:00 he looked in the office but the boss was very busy with the machines because he had wash to do. He had finished working that day but he was in pain. The accident occurred on a Friday and he did not work the weekend. He did not go to work on Monday as he went to the doctor.

- Petitioner testified at that time he was making about $12.25 per hour and worked normally an eight hour day, five days per week regularly (40 hour work week). He indicated he had always been available to work a full, week prior to the injury ($490.00 per week). Petitioner testified on the Monday after the accident he went to see Dr. Jose Castro. Prior to September 9, 2011 Petitioner testified that physically he had no problems doing his full job and had never had any prior major low back injury before that date. Petitioner testified that after he saw the doctor that day, on about September 12 or 13 he went and spoke with Justino and told him that he would be out a week because the doctor was going to do some studies; he understood he had a deviated, displaced disc. Petitioner stated that at that time Petitioner told Justino that he had injured his low back on that prior Friday while working and he had the very severe pain in his back. Petitioner testified when he saw Dr. Castro September 12, 2011 he told the doctor why he was seeking treatment, he expected that in the records. Petitioner did not recall if he had returned to work on that Tuesday. Petitioner testified that he did fill out a written accident report with Respondent; with Justino and Miguel Alfaro. Petitioner filled out the report with what he could understand; as there were parts that he did not comprehend, so he only filled out the parts he did comprehend. Petitioner did not recall if he had returned to work shortly after that, but he had returned to work; the records were indicated he worked in September 2011. Petitioner had continued to treat with Dr. Castro in September and October 2011 and he was doing the same work with the washing machines, pushing and pulling carts that weighed about 400-500 pounds full of clothes, and some were filled

with carpets. Petitioner indicated there was a scale and the carts were weighed and he saw that. He indicated the carpets are washed and go on a belt that empties the product to the cart. He had to push the carpet carts 30-35 feet where they were rolled up. Petitioner noted that the clothes carts did weigh less. There were carpets, clothes, towels, and table clothes in the carts and they weighed different depending on what was in them. Petitioner testified during that time he had continued to work his job and the pain was getting stronger and stronger in his lower back. Petitioner continued to treat with Dr. Castro September through November and in November 2011 he was referred to Dr. Michael Malek by Dr. Castro. Petitioner was having therapy while he was working. He did not recall if he worked November 7, 2011 (12 WC 04491). Petitioner did recall going to Northwest Community Hospital in November with Justino; he went due to the strong pain in his back, because he continued to work with the strong pain in his back and it would have gotten worse. After that point in November 2011 he continued to treat with Dr. Castro and Dr. Malek and he had three back injections; one November 26, 2011. Petitioner indicated the injection did not have any effect. He had the second injection December 9, 2011 and that had no effect; as he continued to work the pain was getting worse. He had the third injection December 23, 2011; he had the third because Dr. Malek said that treatment entailed three injections. He saw Dr. Malek December 30 and the records reflected he was doing better and he was released to light duty, 20 pound restriction. Petitioner did ask Respondent for a position within the restrictions and they did accommodate and Petitioner returned to work. In January 2012 he was folding towels and hanging aprons; different from his normal job duties and he had ability to sit and stand. He was not doing other jobs at that point in 2012. He had continued to treat with the doctors then and before the end of 2012 Dr. Malek recommended surgery which Petitioner had May 16, 2013 and the effect was that he had less pain after the surgery and he had less pain and inflammation in the legs. Petitioner continued with therapy after the surgery and then had a functional capacity evaluation and they released him back to work. Petitioner then requested work within the restrictions and he did return to that work about January 6, 2014; he did not recall what job at that point; he then indicated that he was folding towels at that point either sitting or standing. Petitioner testified then he still had the pain continuing, but less severe in his back. He had worked full eight hour days then and there were others also working that job. He indicated the other works worked all day standing up folding towels. Petitioner indicated Respondent gave him other accommodations; he stated when he got the pain real bad they would give him a chance to lie down in the boss of the truck driver's seat; he did not recall how long he would do that, maybe 1-2 times per day.

- Petitioner was no longer working for Respondent. He indicated at the meeting with Justino and Andres from HR, they said there was no position for Petitioner because the restrictions were permanent; that meeting was about May 22 in Justino's office and the lady from HR was also there with Andres-(the translator). Petitioner indicated Andres told him that until the doctor gave Petitioner a note with changed restrictions they could not return him to work. Petitioner did not keep working after that meeting and he

indicated that he would have liked to keep working. Petitioner had not worked since that meeting. Petitioner indicated he lost a lot. He stated he can no longer do the things he did before; he cannot even walk any long distance because he gets tired. He indicated he can do simple things; he could work light work. He did not know if he could do his old job as he does not feel the same and his back bothers him a lot and he gets tired. Petitioner stated that if he stands or sits too long his back hurts him. Petitioner indicated given his back condition, he did not think he could push full carts of rugs and laundry.

- On cross examination, Petitioner did not recall if he had a conversation with Justin De Vault on September 9, 2011. Petitioner denied telling Mr. De Vault September 9, 2011 that Petitioner was upset about his work hours. Petitioner agreed he alleges a work accident September 9, 2011. Petitioner agreed he did not tell anyone about the accident on that date; he stated he did not tell him that day because Mr. De Vault was not in the office. Petitioner did not recall if he called in sick September 12, 2011. Petitioner testified that he did report the accident (either September 13 or September 14, 2011) but he did not recall the exact date. Petitioner saw Dr. Malek October 7, 2011; Petitioner indicated the doctor always knew about the accident. He did not recall if he gave the doctor a history of the accident when he saw Malek October 7, 2011.

- Petitioner agreed when he started working for Respondent he used the name Juan Fray (SS#XXX-XX-9473—he did not recall the number). Petitioner agreed he later used the SS# XXX-XX-8675. He did not recall the SS# he was currently using. Petitioner denied having three different social security numbers at Respondent.

- Petitioner did not recall giving Dr. Malek a history June 8, 2012 of returning to regular work duty. Petitioner agreed that he is not a US citizen; undocumented. Petitioner did not recall if he worked for Respondent in 2002 up to 2006 under the name Juan Fray. Petitioner did not recall if he changed his name at Respondent in 2007 to Gustavo Dominguez-Zilli. Petitioner did not recall filling out a Personal Information Change form changing his birth date. Petitioner did not recall being told by Respondent October 2006 that they were notified by Social Security that Petitioner's number did not match up. Petitioner agreed after his low back surgery he did return back to work at Respondent and worked full time and earning the same amount as before the accident. Petitioner stopped working for Respondent May 14 and he had not looked for employment since. Petitioner agreed that at his attorney's request he met with Miss Stafseth a vocational rehab counselor. He did not recall informing her that he could not legally work in the United States. He again agreed that he had not looked for work in the U.S. (or any other country) since he last worked at Respondent. He did not recall if he told her that he had worked in Mexico before coming to the U.S. He did not recall telling her that he could operate a forklift. He did not know if she ever tried to find him employment. Petitioner did not recall filling out an accident report 9/14/11. Petitioner did identify his signature at the bottom (RX 7); Petitioner stated that he did not fill it out. Petitioner denied indication there that he did not want to see a doctor.

- On re-direct examination, Petitioner agreed he testified that he had used two different names during his employment with Respondent (he started under Juan Fray Vasquez and then to Gustavo Dominguez-Zilli). He agreed it was his signature on RX 7 and he recognized it as his. Petitioner indicated it was not his writing for other answers on the report and he did not recognize that writing. Petitioner testified that when he was injured September 9, 2011 he had filled out a written history with Respondent of how he was injured and RX 7 was not what he had filled out.

The Commission finds that Petitioner testified of the mechanism of injury and Petitioner's testimony is unrebutted and supported in the evidence. Petitioner did not report the injury on that Friday but he clearly gave timely notice within a week. The initial medical visit did not note the accident in the doctor's notes, but the intake sheet did indicate the work accident. Petitioner's testimony is consistent with the medical records throughout of his ongoing condition of ill-being. Petitioner likewise gave consistent history with Respondent's examiner and vocational rehab people. Petitioner remains on permanent sedentary restrictions and Respondent no longer accommodates the restriction and Petitioner is not a legal citizen so he cannot legally obtain work in the U.S. There is no indication of any prior back history and Petitioner, in fact, had been working for Respondent for many years, albeit under two different names. The evidence and testimony clearly reflects that Petitioner's symptoms never totally abated and left him on the permanent restrictions and ongoing symptoms. The Arbitrator found Petitioner met the burden of proving causal connection regarding 11 WC 46725 (D/A 9/9/11) ((but not accident/CC to 12 WC 04491 (D/A 11/7/11) as there is not even a mention in records of any such occurrence)). The evidence and unrebutted testimony is supported consistently throughout to find Petitioner met the burden of proving causal connection to his current condition of ill-being. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence. And, herein, affirms and adopts the Arbitrator's finding as to causal connection.

The Commission finds as to evidentiary findings and bifurcation, that the Arbitrator did not err given the facts and circumstances presented. Given the testimony at the end of the 1st day, there was clearly need for the matter to be bifurcated and clearly within the discretion of the Arbitrator.

The Commission, with the above finding of ongoing causal connection, further finds evidence of Petitioner being still on the permanent sedentary restrictions and Respondent no longer accommodating the restriction, and Petitioner being unable to find sedentary work given his unskilled labor history, and inability to legally work in the U.S. and other factors. With above causal connection findings the evidence and testimony finds Petitioner met the burden of proving entitlement to the temporary total disability-(TTD) benefits as awarded, and the denial of maintenance.

16IWCC0364

The Commission, with the above finding of ongoing causal connection, further finds evidence of Petitioner's ongoing treatment through fusion surgery with the records supporting the medical bills in evidence. With above causal connection that the evidence and testimony finds Petitioner met the burden of proving entitlement to the medical benefits as awarded. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to medical expenses.

The Commission finds that Respondent clearly had some questions of compensability based on causal connection and through surgery and the permanent restrictions. Respondent clearly had accommodated the restrictions to the time of surgery and based on their §12 examination denied payment of benefits. Respondent's actions do not appear in bad faith or as vexatious behavior to rise to the level to warrant penalties here. Petitioner failed to meet the burden of proving entitlement to such remedy. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to denial of penalties and attorney fees.

The Commission finds that the issue of permanency was not determined by the Arbitrator as it was heard under §19(b), the matter, herein, is remanded to the Arbitrator for that determination. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, given the fact the matter was heard under §19(b).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 15, 2015 is hereby affirmed and adopted.

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

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

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

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

DATED:
o-4/21/16
DLG/jsf
045

JUN 1 - 2016

David Gore

Joshua Luskin

Mario Basurto

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

DOMINGUEZ-ZILLI, GUSTAVO
Employee/Petitioner

Case# **11WC046725**

12WC004491

16IWCC0364

CINTAS
Employer/Respondent

On 10/15/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2512 THE ROMAKER LAW FIRM
PATRICK SEROWKA
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

0075 POWER & CRONIN LTD
ROBERT E LUEDKE
900 COMMERCE DR SUITE 300
OAK BROOK, IL 60523

16IWCC0364

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)

Gustavo Dominguez-Zilli
Employee/Petitioner

v.

Cintas
Employer/Respondent

Case # **11 WC 46725**

Consolidated case: **12 WC 4491**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **04/29/15 & 06/22/15.** 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. ☒ 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 **09/9/11 & 11/7/11**, Respondent ***was*** operating under and subject to the provisions of the Act.
On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.
On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.
Timely notice of this accident ***was*** given to Respondent.
Petitioner's current condition of ill-being ***is*** causally related to the accident.
In the year preceding the injury, Petitioner earned **$24,774.53**; the average weekly wage was **$476.80**.
On the date of accident, Petitioner was **54** years of age, single with no dependent children.
Petitioner has received all reasonable and necessary medical services.
Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD. $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.
Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER FOR 11WC46725

TTD
Respondent shall pay Petitioner TTD for a period of 41 & 4/7 weeks at a rate of $317.87, as provided in Section 8(b) of the Act. No maintenance is awarded.

Medical benefits
Respondent shall pay Petitioner $37,228.09 for Dr. Malek's bill; $38,427.89 for bills from Fullerton Surgery Center; the bills for Our Lady of Resurrection, in the amount of $57,659.45; the bills for N.R. Anesthesia, in the amount of $5,152.04; and the bills for Lakeshore Surgery Center in the amount of $21,450.16, as provided in Sections 8(a) and 8.2 of the Act.

Penalties
No penalties or attorney's fees are awarded pursuant to the Act.

Order for 12WC4491
No benefits are awarded pursuant to the Act.

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

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

FINDINGS OF FACT

The disputed issues in these matters are: 1) accident; 2) notice; 3) causal connection; 4) earnings; 5) average weekly wage; 6) medical bills; 7) temporary total disability; 8) maintenance; 9) penalties; and 10) attorney's fees. *See,* AX1.

Petitioner's testimony regarding the accident date of September 9, 2011; (11WC46725)

The petitioner testified that he had been working for Respondent for approximately fifteen (15) years and that on September 9, 2011, while performing a different job than usual, he injured his lower back. This testimony is unrebutted. He also testified that he originally started working for Respondent under the name Juan Fray Vasquez however, when his documents were challenged by the government, Petitioner presented new documents to Respondent under the name of Gustavo Dominguez-Zilli. The respondent accepted these documents and continued Petitioner's employment, under the new name and social security number. Tr. of 4/29/15, pp. 7-19; PX8 pp.6-32.

Petitioner further testified that on September 9, 2011, the truck loaders did not show up for work and he was told to unload the truck with another person. While picking up a pile of clothes, he felt a pain in the lower part of his back. He did not tell anyone about it that day because his supervisor was busy with the machines. This was a Friday toward the end of his shift. On Monday, the petitioner presented to Dr. Ramon J. Castro.

Petitioner further testified that some time after treatment he was given sedentary restrictions and after a meeting with his supervisor and a co-worker acting as interpreter, his employment with Respondent was terminated on May 22, 2014, after his restrictions were made permanent by Drs. Castro and Malek. He has not looked for a job since he was terminated and denied that he told his supervisor that he would not go to the "company clinic"; does not remember if he called in sick on September 12, 2011; and currently does not know if he could perform his old job because of his back pain.

Petitioner's testimony regarding the accident date of November 7 2011; (12WC4491)

Petitioner testified that he did not remember if he worked on November 7, 2011, but testified that he did go to the hospital with a person named Justino, on that date. The medical records of Northwest Community Hospital show that the petitioner was seen on November 8, 2011, for a "workers comp back injury". He was discharged the same day and told to follow-up with Dr. Castro. PX2.

Testimony of Kari Stafseth, Petitioner's vocational rehabilitation counselor

Petitioner called Ms. Stafseth, a certified rehabilitation counselor, who testified that she met with the petitioner, evaluated him and drafted a report regarding his potential employment capabilities. According to her, because the petitioner never had formal training or education, petitioner is unskilled, cannot speak English, and cannot return to his previous employment because of his restrictions and the Mexican job market is slanted toward young males. Therefore, there is no viable stable job market for the petitioner in the United States or Mexico. On cross-examination, Ms. Stafseth testified that there are Spanish speaking people with disabilities, working in the Unites States, as long as they are legally employable. Tr. 6/2/15, pp. 111-155.

Petitioner's treatment

On September 12, 2011, Petitioner presented to Dr. Castro and a patient history was taken which states under Present Ailment "low back pain radiating to both legs...he was lifting and unloading clothes". On September 14, 2011, the doctor's notes state the same mechanism of injury and the petitioner was taken off work. PX1, pp. 17-21.

Petitioner continued treating with Dr. Castro through on or about September 4, 2014, diagnosed as having a herniated disc and lumbar radiculopathy. On October 29, 2012, Petitioner was prescribed work hardening, a functional capacity evaluation ("FCE") and was returned to work on or about January 11, 2012. PX3, pp. 24-75.

Petitioner also treated with Dr. Michel H. Malek on or about October 7, 2011, referred by Dr. Castro. The medical notes state that the petitioner had been having low back pain, radiating down both lower extremities, for the past three weeks. There was no neck pain, headaches or radicular symptoms around the chest or upper extremities, but pain did radiate into the upper lumbar region. Walking was bothersome and "the patient states that he is a machine operator and his work has aggravated his condition." The September 16, 2011 MRI scan of the lumbar spine "shows evidence of desiccation, central disc herniation at L5-S1, evidence of bulging at L3-4, L4-5, with evidence of foraminal narrowing at L5-S1, bilaterally." Dr. Malek recommended injections, which were performed on November 26, 2011, December 9, 2011 and December 23, 2011. Petitioner was released to return to work in a light duty capacity on December 30, 2011; which he testified he did. PX3, pp. 22-36; Tr. pp. 36-39.

On January 6, 2012, Dr. Malek recommended a conditioning program for two to four weeks, followed by a functional capacity evaluation ("FCE"). Petitioner was to return to work with restrictions on January 11, 2012. As of February 3, 2012, Petitioner did not have the conditioning program but had returned to work for eight (8) hours however,

after four (4) hours, the pain increased. Dr. Malek stated that after the conditioning program, Petitioner could return to work and would be at maximum medical improvement ("MMI"). PX3, pp. 37-39.

Dr. Malek's next entry is dated June 8, 2012, where he is still strongly recommending a conditioning program followed by an FCE. On November 2, 2012, Dr. Malek states that the conditioning program still has not been done therefore he opines that the next step is to proceed with an EMG/NCV of the bilateral lower extremities, lumbar discography and a repeat MRI. The patient's MMI status was rescinded. PX1 & 3, pp. 40-43.

On November 30, 2012, Dr. Malek notes the IME with Dr. Ryan Hennessey on May 25, 2012, in which Dr. Hennessey states that the petitioner symptoms were not reported until five (5) days after the injury therefore, he questions causation. The Arbitrator notes that the petitioner reported lower back pain with radiation three (3) days after the accident, on September 12, 2011. Dr. Malek explained that in his experience, "this is actually not a reason to question causation, but actually adds to the credibility of the patient. Credible people, after an injury, will wait to see if the pain progresses, persists, prior to reporting it as most people do not want to start a workman's comp process unless they are sure the symptoms are persistent. In this case, the patient did wait to see if the symptoms would go away and only when they did not, he made his report." The doctor challenges Dr. Hennessey's statement that the petitioner's examination is normal, as the EMG/NCV proved Dr. Hennessey's conclusions were incorrect. PX3, pp. 44-47.
On December 7, 2012, a discogram was performed which was purported to be "positive at the L5-S1 level, with contribution from L3-4, L4-5. Post-discogram CT done 12/7/12 showed grade IV tear at the L5-S1, L3-4 and L4-5." Petitioner was to return to work with restrictions. PX3, pp. 48-54.

On January 2, 2013, Petitioner presented to Dr. Malek, who noted that his repeat MRI of the lumbar spine performed on December 22, 20112 showed 1) pathology at L3-4, L4-5, L5-S1, with evidence of desiccation of the disc at three levels, with symptoms worsened at L3-4 and L5-S1; 2) disc herniation at L5-S1 and moderate right foraminal narrowing at L5-S1; and 3) moderate left foraminal narrowing at L4-5. Surgery was discussed. A second opinion was obtained from Dr. Yapoor, who stated that the petitioner's condition was causally related to the work activity and recommended a three-level fusion. Petitioner was returned to work with restrictions. PX3, pp. 55-64; PX4.

The petitioner was subsequently seen on February 20, 2913, April 1, 2013, May 13, 2013, with surgery taking place on May 16, 2013, i.e., a L5-S1 fusion with L4-5 decompression.

The insurance company only authorized the L5-S1 fusion, with no allowance for surgery at L3-4 or L4-5. Px3 pp. 64-88.

On the May 24, 2013 follow-up, Petitioner presented to Dr. Malek with intense surgical back pain and pain radiating down his leg. By June 10, 2013, the petitioner was much better, still wearing a brace, off work and by December 20, 2013, he was returned to work in a sedentary position per an FCE performed on October 8, 2013.

On January 6, 2014, the petitioner returned to work, folding towels and on May 5, 2014, the doctor notes that the petitioner is not tolerating sedentary work and he was taken off work, pending a job description analysis. PX3, pp. 89-116.

Deposition of Ryon M. Hennessy, September 18, 2013

Dr. Hennessy testified that he examined the petitioner on May 25, 2012 after a review of Dr. Castro's notes and radiographic films. Dr. Hennessy further testified that although the petitioner complained of a work accident on September 12, 2011, "there was no mention of any work injury or trauma" in Dr. Castro's notes, on the initial visit. The Arbitrator notes that on September 12, 2011, Petitioner presented to Dr. Castro and a patient history was executed which states under Present Ailment "low back pain radiating to both legs...he was lifting and unloading clothes" and that this was the initial visit. Dr. Hennessy further testified that there was no positive Waddell sign although the petitioner was moving slowly. Petitioner "demonstrated 5 out of 5 strength in both upper and lower extremities....and there was no deformity of his lumbar spine." This doctor's diagnosis was "a lumbar strain". He further testified that "there was no correlation between the subjective radiculopathy and the MRI findings, therefore the epidurals themselves would not be related to the accident of 9-9-2011, as epidurals are to treat radiculopathy." He determined the petitioner to be at maximum medical improvement ("MMI"). RX3.

Deposition of Dr. Kenneth Smith, February 25, 2015

This doctor testified that he did a review of Petitioner's records and that he originally concluded that the L5-S1 spinal fusion with fixation and grafting was not reasonable or necessary. However, after further review, he thought that Drs. Malek and Yapoor had a reasonable basis for the fusion recommendation and that the requested bilateral laminectomy with nerve root decompression should be certified. He further testified that he was not familiar with the URAC standards. PX6 & RX4.

Deposition of Dr. M. Bryan Neal, April 17, 2015

Dr. Neal examined the petitioner on November 17, 2014 and noted that Petitioner stated he was in a lot of pain after lumbar surgery. He was taking hydrocodone on a daily

basis. Dr. Neal diagnosis of the petitioner was "low back pain with lower extremity pain and parenthesis bilaterally, status post L5-S1 arthrodesis and L4-L5 decompression spinal surgery". The doctor's impairment rating, based on the AMA Guidelines was a class grade of "E" "which is the highest grade and the highest impairment" that the doctor could assign; he found that the petitioner "had a 9% whole person impairment." Rx2.

Testimony of Anna Ahlborn, Respondent's vocational rehabilitation counselor

Ms. Ahlborn testified that she is a certified rehabilitation counselor, who met with petitioner on November 13, 2014, for an initial assessment, after review of his FCE and other documents. She further testified that she looked for jobs in Mexico only because the petitioner does not have legal status to work in the United States. She testified that she was able to find appropriate jobs for the petitioner, in Mexico. Upon cross-examination, Ms. Ahlborn agreed that the petitioner could not return to his pre-injury job at the respondent's place of employment however, Petitioner could be competitive in seeking other jobs. Tr. 4/29/15, pp. 102-170.

Testimony of Respondent's witnesses

Mr. Miguel Alfaro testified that he is employed by Respondent and has worked in one capacity or another since June of 1996. He was first shift supervisor when the petitioner was employed in September of 2011. He further testified that he was in a meeting with the petitioner and Justin DeVault, acting as translator, in September of 2011. He could not remember the exact date. He testified regarding Petitioner's exhibit 20, i.e., the accident report, also Petitioner's exhibit 8. Tr. 6/22/15, pp. 22-60.

Mr. Justin DeVault testified that he wrote the investigative report for Petitioner's accident and conducted an Ishikawa review of the accident, to identify the root cause of it. He further testified to a report he authored, explaining the accident and that the petitioner initially reported being sick and then came back and said he had an accident. Tr. 6/22/15, pp. 65-84.

Respondent introduced into evidence medical bills, pursuant to Section 8.2 of the Act in its exhibit 5 and petitioner introduced into evidence, medical bills as its exhibit 16.

CONCLUSIONS OF LAW

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

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

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

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

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial*

Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

Regarding case number 11 WC 46725, the petitioner has testified that he had an accident at work on September 9, 2011, by which he injured his lower back. This testimony was not rebutted. Petitioner's medical records support his claim therefore the Arbitrator finds that the petitioner has proven, by a preponderance of the evidence, that he had an accident that arose out of and in the course of his employment by Respondent.

Regarding case number 12 WC 04491 the Arbitrator does not find that the petitioner has proven, by a preponderance of the evidence, that he had a second accident, as his testimony was vague and he stated that he went to the hospital on November 7, 2011. The Arbitrator finds that the medical records show that Petitioner went to the hospital on November 8, 2011, the next day; and there is no mention of a new accident.

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

The Arbitrator finds that timely notice was given for the accident in case number 11 WC 46725 however, the Arbitrator finds no evidence of notice given of a November 7, 2011 accident in case number 12 WC 04491.

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

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n*, 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n*, 283 Ill. App. 3d 607, 610 (1998).

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v.*

Industrial Comm'n, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986). The Arbitrator finds that the petitioner has proven, by a preponderance of the evidence, that his current condition of ill-being is causally related to the accident in case number 11 WC 46725 however, he has not proven that issue in case number 12 WC 04491.

G. What were Petitioner's earnings?

The petitioner testified that in September 2011, he earned $12.25 per hour and worked eight hours a day, five days a week. There is a dispute between the parties' the petitioner states that his earnings preceding the injury were $24,774.53, with an average weekly wage of $476.80 and the Respondent states that the petitioner's average weekly wage was $320.00. The respondent has not offered evidence to support its average weekly wage statement therefore, the Arbitrator finds and concluded that the Petitioner's average weekly wage is that stated on the Request for Hearing, i.e., $476.80.

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

The Arbitrator finds that certain medical services were necessary and reasonable and are awarded by the Arbitrator and are to be paid to the petitioner, pursuant to the fee schedule as provided in Section 8.2 of the Act. However, the Arbitrator also finds and concludes that some charges were unrelated to the work accident and unnecessary and unreasonable i.e. charges by Hispanic Regional Clinics for a general profile in the amount of $230.00; acute hepatitis panel, in the amount of $300.00; numerous 15 minute manual massages for $200.00 each. Dr. Malek's bill, in the amount of $37, 228.09 is reasonable and necessary. The bills for Fullerton Surgery Center in the amount of $38,427.89 were reasonable and necessary; the bills for Our Lady of Resurrection, in the amount of $57,659.45, were reasonable and necessary; the bills for N.R. Anesthesia, in the amOpunt of $5,152.04, were reasonable and necessary; the bills for Lakeshore Surgery Center. In the amount of $21,450.16, were reasonable and necessary; and Dr. Malek's bills were reasonable and necessary. As this matter is a 19(b), only those bills determined to be reasonable and necessary will be paid by the Respondent pursuant to the medical fee schedule and the remaining bills will be presented by the petitioner, at a later date.

L. What temporary benefits are in dispute?

On the Request for Hearing, the petitioner claims to be entitled to TTD for a period of 106 & 6/7 weeks, from November 8, 2011 through January 5, 2014; and maintenance for 49 & 6/7 weeks, from May 15, 2014 through April 29, 2015. The Arbitrator does not agree. Petitioner was released to return to work in a light duty capacity on December 30, 2011; which he testified he did. On January 6, 2012, Dr. Malek recommended a conditioning program for two to four weeks, followed by an FCE. Petitioner was to return to work with restrictions on January 11, 2012. On February 3, 2012, Petitioner had not had the conditioning program but had returned to work for eight (8) hours however and after four (4) hours, the pain increased. The petitioner was subsequently seen on February 20, 2913, April 1, 2013, May 13, 2013, with surgery taking place on May 16, 2013, i.e., a L5-S1 fusion with L4-5 decompression. The insurance company only authorized the L5-S1 fusion, with no allowance for L3-4 or L4-5. On December 7, 2012, a discogram was performed, which was purported to be "positive at the L5-S1 level, with contribution from L3-4, L4-5. Post-discogram CT done 12/7/12 showed grade IV tear at the L5-S1, L3-4 and L4-5." Petitioner was to return to work with restrictions. PX3, pp. 48-54.

On the May 24, 2013 follow-up, Petitioner presented to Dr. Malek with intense back pain radiating down his leg. By June 10, 2013, the petitioner was much better, still wearing a brace, off work and by December 20, 2013, he was returned to work in a sedentary position per an FCE performed on October 8, 2013.

On January 6, 2014, the petitioner returned to work, folding towels and on May 5, 2014, the doctor notes that the petitioner is not tolerating sedentary work and he was taken off work, pending a job description analysis. Therefore, the Arbitrator concludes that the petitioner is entitled to TTD from November 8, 2011 through December 31, 2011; May 16, 2013 through December 20, 2013; and May 5, 2014 through May 22, 2014, his termination date. The total is 41 & 4/7 weeks.

With regards to entitlement to maintenance, the Arbitrator finds and concludes that the petitioner did not participate in a viable plan for rehabilitation as he testified that he has not looked for work since he was terminated and does not remember if he told the rehabilitation counselor that he could not legally work in the United States. The Arbitrator finds that the petitioner has not proven, by a preponderance of the evidence, that he is entitled to maintenance, pursuant to the Act.

M. Should penalties or fees be imposed upon Respondent?

Illinois courts have refused to assess penalties under sections 19(k) and (l) of the Act where the evidence indicates that the employer reasonably could have believed that the

employee was not entitled to the compensation withheld. *See, Board of Education v. Industrial Commission*, 93 Ill.2d 1, 442 N.E.2d 861 (1982); S*ee also, Avon Products, Inc. v. Industrial Commission,* 82 Ill. 2d 297 (1980) and *Brinkmann v. Industrial Commission*, 82 Ill. 2d 462 (1980). "Where a delay has occurred in payment of workmen's compensation benefits, the employer bears the burden of justifying the delay, and the standard we hold him to is one of objective reasonableness in his belief." *Id. See also, City of Chicago v. Industrial Commission*, 63 Ill. 2d 99 (1976).

The Illinois Supreme Court has explicitly found an obligation on the part of Respondents to diligently obtain information regarding a Petitioner's claim in *Board of Educ. v. Industrial Comm'n*, 93 Ill. 2d 1, 66 Ill. Dec. 300, 442 N.E.2d 861 (1982). In *Board of Educ.*, the court found that the Chicago Board of Education "had or should reasonably have had in its possession" sufficient evidence, that "would have disclosed that the grounds for challenging temporary total disability liability were insubstantial at best," and therefore fees and penalties were warranted. The Supreme Court also found that the Board's "failure to obtain that information did not entitle the Board to assert later that it acted in good faith because it was ignorant of the evidence in favor of the employee." *See, Board of Educ. v. Industrial Comm'n*, 93 Ill. 2d 1, 66 Ill. Dec. 300, 442 N.E.2d 861 (1982). The Arbitrator does not finds that the respondent's behavior, in the subject case, rises to the level of unreasonable and vexatious therefore no penalties are awarded.

Both parties presented proposed statement as the nature and extent of Petitioner's injuries, after the petitioner argued vehemently, that this matter is being brought under Section 19(b) of the Illinois Workers' Compensation Act, (the "Act"). The Arbitrator finds that although this matter was brought under Section 19(b); both parties provided testimony from rehabilitation counselors; and both parties presented a position on nature and extent. The Arbitrator finds that this matter was brought under Section 19(b) therefore; any determination of the nature and extent of Petitioner's injuries is moot and will not be addressed. *See,* Tr. pg. 76.

16IWCC0364

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
11WC46725 & 12WC4491
SIGNATURE PAGE

Signature of Arbitrator

October 15, 2015
Date of Decision

OCT 15 2015

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maurice Fleming,

Petitioner,

vs.

NO: 15 WC 08116

Manpower, Inc.,

16IWCC0365

Respondent.

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner is a 45 year old employee of Respondent, who described his job as bag dump operator. Respondent is a temp company and he worked through Pinnacle Food for the past 10 months. He was regularly scheduled to work 40 hours per week and mandatory overtime. He testified prior to the accident he had not missed 5 days of work for reasons beyond his control like sickness, family emergency, no work available. He had taken part

of a day for a doctor appointment. In his job he had an electric tow motor that would move the skids from the station area. He had three-(3) places to tend and he staged the pallets to where he had a bag dump. Depending on the setup he would have to move from side to side, twist over, cut the bag, open it, lift the bag up and toss it into the dumpster. There were different ingredients he dumped like salt, baking soda, flour, starch. The bags he worked with weighed 50 pounds and each day varied to 300 or more bags dumped per day. He had to load the bags onto the pallet (electric tow truck) and move them on the truck. Petitioner did not have any x-rays or MRI's of his back in the year before this accident and before he had never seen an orthopedic specialist for his back.

- On the date of accident, February 4, 2015, Petitioner testified that he was staging and getting ready to stage for the bag dump that he had already done, to replace the one he had done. Petitioner stated that he was picking up a 50 pound bag of salt and as he was picking it up and he turned and he felt a pull in his back. He stated it was discomfort and it occurred at about 3:00; his shift ended at 4:00. He stated the rest of his shift he took it a little bit easy. He stated that his lower back was hurting and it extended to his hip and groin area. Petitioner testified that the week of this hearing he had an SI joint injection and prior to that injection he had been in constant pain from the day of this accident.

- Petitioner testified that on the day of the accident he went to the emergency room-(ER) and then he had followed up with Dr. Roger Joy, on July 5, 2015, the day after this accident. Petitioner testified that he did fill out an accident report at Manpower February 6, 2015. Dr. Joy had referred Petitioner to a specialist, Dr. Kovalsky and Petitioner had been under continuous care since the accident. The SI injection he had prior to hearing had then been providing current relief and prior to that injection nothing had provided him relief from the pain. Petitioner testified that immediately after the accident the doctor had given him restrictions of 14 days on light duty and he took the note to Respondent and they could not accommodate the restrictions, and after those 14 days the doctor authorized Petitioner off of work altogether. Petitioner had returned to work for a period of time in March and he was then sitting down and in pain. He stated he had returned to Dr. Joy and the doctor had taken him off work until further notice and he had not returned to work since then. He had not returned to work as the doctor had not released him to return to work.

- Petitioner testified that prior to the SI injection he had pain in his groin and right side hip and right side lower back at a pain level of 9/10 and it was constant. Prior to the injection, in pain, he did not know how much he could pick up off the ground as he had not done it. He had been able to walk around or stand for about 30 minutes before the pain that he felt he had to sit. Petitioner testified that while he had been off he had not been paid from Respondent or an insurance company and he had never received a letter explaining why he was not being paid while off work. Petitioner agreed he had asked his attorney to write a letter and make an effort to secure Petitioner payment while he was off work.

The Commission finds that there is indication in the medical records that Petitioner had some back pain prior to February 4, 2015, however, Petitioner clearly kept working that heavy job dumping the heavy bags of product for productions. As Petitioner noted in testimony, doing that type of work you would conceivably get sore. Petitioner did that lifting, bending, twisting work with the heavy job repetitively, but it was not until that specific February 4, 2015 incident that aggravated Petitioner's back to the breaking point and ongoing symptoms that had not abated, but for post the recent SI injection providing some relief. The Commission notes that Petitioner did not report anything work related when he presented to St. Mary Hospital ER on February 4, 2015 and he was evaluated for chest pain and low back pain. Petitioner had reported to Dr. Roger C. Joy, February 5, 2015- and it was noted that patient presents for follow up for strain right lower back, discomfort started about a month ago and had gotten worse, he lifts repetitive at place of employment; seen in ER. Restrictions nothing over 25 pounds. Thereafter, the records indicated the relationship to a work incident. Dr. Joy did indicate a causal opinion.

The Commission notes Dr. Kovalsky records--

--April 9, 2015-history of—low back pain-(LBP) more right. Not working; further noted radicular leg pain, numbness

--April 2, 2015-noted injury February 4, 2015, patient was lifting and carrying and twisting and felt immediate back pain with radiation to right buttock and thigh. Denied prior LBP or leg problems. They noted he went to ER and Dr. Joy and was sent for an MRI. Off work since February; No therapy yet. MRI shows slight bulging L3-4, 4-5; age related; not pathologic injury; no herniations or annular tears. Clinical diagnosis noted as right SI joint dysfunction. Symptoms 2 months and to be put on oral steroids; If not improving to consider SI injections.

--May 29, 2015-pain at 9/10. Patient has not been able to work since February due to pain. SI tenderness and over right ileum. SI joint positive. Neuro intact. Diagnostic for SI dysfunction. Discussed surgery; to try injections and therapy.

The Commission notes that Dr. Kovalsky's records are silent as to a causal connection opinion, but, the records do set out a clear mechanism of injury to otherwise support causation.

The Commission notes that Respondent's witness, Mr. Buretta, Petitioner's supervisor at Pinnacle, testified that Petitioner did not report an accident to him at all, but he was questioned by his supervisor days later and he learned of it. While the Pinnacle pamphlet indicated reporting accident's 'immediately', While Mr. Buretta did not receive 'immediate' notice, Petitioner clearly reported it to Respondent, Manpower, and their accident report was dated and signed by Petitioner two days later; the Pinnacle rules obviously do not give a higher reporting standard than the Act. Had Petitioner been a Pinnacle employee and not reported the incident until two days later, an accident was still reported and Mr. Buretta would have still received proper, timely notice, whether he believed an accident actually occurred or not.

The Commission finds that Petitioner's testimony is really unrebutted and generally supported in the medical records (but for the initial ER that was silent as to a work incident); but Petitioner also had chest pain which an ER would consider more important and pressing issue to explore. And again, Petitioner reported the back pain to Dr. Joy the next day, albeit, as a 'follow up' for low back pain related to work, rather than a specific lifting, twisting incident February 4, 2015.

16IWCC0365

The evidence and basically unrebutted credible testimony in this record finds that Petitioner met the burden of proving a specific accident that arose out of and in the course of employment February 4, 2015 (possibly aggravating pain from repetitive heavy work) and further finds Petitioner met the burden of proving a causal relationship between that specific incident to his ongoing condition of ill-being. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding of accident, as well as, affirms and adopts the Arbitrator's finding as to causal connection.

The Commission, with the findings above of accident and causal connection, further finds the medical records either restricting Petitioner or keeping him completely off work to find that Petitioner met the burden of proving entitlement to the temporary total disability-(TTD) awarded. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to total temporary disability.

The Commission, with the finding above of accident and causal connection, further finds the medical records to support Petitioner's ongoing condition of ill-being and treatment and need for further treatment to find that Petitioner met the burden of proving the medical causation. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to medical expenses.

The Commission, with the finding above of accident and causal connection, further finds the medical records and Petitioner's testimony, and the Petitioner's demands for benefits, The Commission, however, does not find a lack of a reasonable basis for Respondent's denial of benefits. It is clear that Petitioner did not report 'immediately' to Pinnacle and there is the lack of history of a work injury in the ER records, and also a lack of a narrative causal opinion from Dr. Kovalsky, as noted in Respondent's response to Petitioner's penalty petition. The Commission notes that while the records indicating a mechanism of injury consistent to support a causal relationship and then there is the later causal opinion of Dr. Joy, there was still a reasonable basis for Respondent to question compensability with the evidence presented. The evidence and testimony finds Respondent's basis for denial of benefits was not unreasonable and not vexatious and to find Petitioner, therefore, failed to meet the burden of proving entitlement to the penalties and attorney fees awarded by the Arbitrator, and therefore, the Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and herein, reverses the Arbitrator's finding as to penalties and attorney fees to deny any and all penalties and attorney fees under the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $279.44 per week for a period of 21 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 the Arbitrator's award of penalties and attorney fees is reversed to deny any and all penalties and attorney fees under §19(k), §19(l), & §16, of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,000.00. 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: JUN 1 - 2016
d-4/7/16
DLG/jsf
045

David S. Gore

David Gore

Stephen J. Mathis

Stephen Mathis

Mario Basurto

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

FLEMING, MAURICE
Employee/Petitioner

Case# **15WC008116**

16IWCC0365

MANPOWER INC
Employer/Respondent

On 8/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.20% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0384 NELSON & NELSON
REED C NELSON
420 N HIGH ST
BELLEVILLE, IL 62220

2795 HENNESSEY & ROACH PC
RICARD A DAY
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

16IWCC0365

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
19(b)

Maurice Fleming
Employee/Petitioner

v.

Manpower, Inc.
Employer/Respondent

Case # **15** WC **008116**

Consolidated cases: _____

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

DISPUTED ISSUES

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

16IWCC0365

FINDINGS

On **02/04/15**, Respondent, **Manpower, Inc.** *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 **$17,974.82**; the average weekly wage was **$418.95**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **1** dependent children.

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

Necessary medical services ***have not*** been provided by the respondent.

ORDER

Respondent shall pay Petitioner 21 weeks of temporary total disability benefits that have accrued from 2/05/15 through **07/10/15**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay to Petitioner penalties of **$1,173.65**, as provided in Section 16 of the Act; $ **2,934.12**, as provided in Section 19(k) of the Act; and **$4,410.00**, as provided in Section 19(l) of the Act.

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

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

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

Signature of Arbitrator

8/24/15
Date

ICArbDec19(b)

AUG 28 2015

Maurice Fleming v. Manpower, Inc.: Case No. 15 WC 008116

FINDINGS OF FACT AND CONCLUSION OF LAW

The issues in dispute are accident, causation, TTD and penalties.

The Arbitrator finds as follows:

The Arbitrator considers the testimony of Petitioner, Maurice Fleming. Mr. Fleming is a 45 year-old African American man who worked for the Respondent since April of 2014. He suffered a work related injury on February 4, 2015.

Petitioner works as a bag dump operator. The job requires him to lift bags of ingredients weighing as much as 50 pounds. (Transcript 11). Each bag is lifted twice. First the bag is loaded onto a pallet in the staging area. The pallet is then wheeled to the bag dump area where Petitioner lifts the bag off of the pallet, turns, and dumps the bag into the bag dump. (T 12).

On February 4, 2015, while Petitioner was lifting a 50 pound bag of salt to place it on a pallet, he felt a "pull" in his back. (T 13). The injury occurred at 3:00 pm. (T. 13, Petitioner's Exhibit 1, First Report of Injury). His shift ended at 4:00 pm after which, he went immediately to the ER. (T 13-15, Petitioner's Exhibit 2, Medical Records – St. Mary's Centralia).

Petitioner complained of back pain and chest pain at the ER. (PX 2). Much of the care he received at the ER was precautionary and related to the chest pain. He was also given a drug test, which was negative. (PX 2). However, upon discharge, his primary diagnosis was muscle strain. He was prescribed Flexeril for muscle spasms, Hydrocodone-acetaminophen for pain, and Naproxen for pain. (PX 2). He followed up with his primary care physician the next day.

On February 5th, 2015, Petitioner saw his primary care physician, Dr. Roger Joy. (Petitioner's Exhibit 3, Medical Records Dr. Roger C. Joy). Records from that visit indicate that Petitioner was being seen in follow-up for a "strain". (PX 3). Dr. Joy did note that Petitioner had discomfort for approximately one month, but noted that the pain had gotten worse. (PX 3). There was no mention of chest pain in the record from this day. Dr. Joy diagnosed Petitioner with back pain and prescribed Dolobid, Norco, Zanaflex, Analgesia gel and physical therapy. He restricted his work to no lifting over 25 pounds for two weeks. (PX 3).

Mr. Fleming's employer could not accommodate those restrictions. (T. 38). Two days after the injury, on February 6th, 2015, Mr. Fleming filled out a report of injury, indicating that he was injured at 3:00pm on February 4th, 2015 and turned it into Manpower, Inc. (PX 1).

On 2/19/15 Mr. Fleming returned to Dr. Joy with complaints of low back pain and pain in the right paraspinals area. Dr. Joy noted that Petitioner had not yet had physical therapy. (PX 3). Dr. Joy wanted him to have physical therapy before returning to work because Dr. Joy believed the nature of his work would aggravate the strain. (PX 3). He authorized Mr. Fleming off work until 2/24/15. (PX 3).

On 2/24/15, Dr. Joy again noted a lumbar strain in the right paraspinals at L3-5. (PX 3). Dr. Joy noted that Petitioner had only completed one physical therapy session, so he authorized him off work until 3/06/15. (PX 3). On 3/06/15, Dr. Joy stated that the visit was a follow-up for low back pain in the lumbar region from L2-S1 and opined, "this was due to lifting, which he does at his place of employment." (PX 3). Dr. Joy noted some radicular symptoms in the lumbar sacral area. Petitioner also experienced pain in his lower back and sacral area during forward flexion, and turning to either side. Dr. Joy noted some improvement with physical therapy, but did not believe that Petitioner was ready for full duty work. (PX 3). Dr. Joy released Petitioner to light duty, gave him Toradol in the office, and recommended a TENS unit for home treatment. (PX 3).

Petitioner presented the restrictions to Manpower and worked light duty employment for one week before he was taken off work again by Dr. Joy on 3/16/15. (T. 18, 39, PX 3). As of 3/16/15, Petitioner underwent 8 physical therapy visits, but his back continued to bother him. (PX 3). He rated his pain as a 7/10 and had decreased range of motion. He also complained of tenderness to palpation in his lumbar area extending into the right buttock. (PX 3).

Petitioner was referred to Dr. Kovalsky and came under his care on 4/29/15. (PX 4). Dr. Kovalsky noted an onset about two months prior. (PX 4). Petitioner complained of pain in his back with numbness down his right leg. He had a normal straight leg test, but an abnormal SI joint exam. (PX 3). Dr. Kovalsky noted abnormal SI joint findings in four separate tests: Fortin finger pointing test, Patrick's/Fabre's test, thigh thrust test and pelvic distraction test. (PX 4). Dr. Kovalsky's record from that day states, "He was injured on February 4th. He was lifting and carrying and twisting, felt immediate pain in his back with radiation into right buttock and thigh. He denies ever having back pain or leg problems similar to this." (PX 4). Based on the exam findings and lack of findings on x-ray and MRI, Dr. Kovalsky diagnosed Mr. Fleming with right SI dysfunction. (PX 4). Dr. Kovalsky noted that the symptoms had only been present for about two months. He prescribed oral steroids and physical therapy with a therapist who was experienced in SI joint manipulation and kept Mr. Fleming off work until the next visit. (PX 4).

On 5/19/15 Petitioner returned to Dr. Kovalsky. Mr. Fleming reported that the prednisone provided some relief in the first week or so, while he was on the higher doses of the steroid, but the symptoms returned as the doses tapered down. (PX 4). Petitioner was using Tramadol to control his pain. (PX 4). Dr. Kovalsky believed a diagnostic steroid injection was warranted. He stated, "I feel bad that he has this problem and can't work." (PX 4). Dr. Kovalsky noted that it would be best for Mr.

Fleming to see one of two therapists who are adept at treating SI joint dysfunctions, but because Mr. Fleming's workers' compensation insurance was not picking up the claim, he only had IDPA for medical insurance and those therapists would not accept IDPA. (PX 4). He was taken off work until two weeks after the injection. (PX 4).

Mr. Fleming had the injection just two days prior to the hearing. (T. 16). It is the only treatment that has provided significant relief from the pain. (T. 16).

The Arbitrator Concludes:

Issue (C): Did an Accident Occur that Arose out of and in the Course of Petitioner's Employment

Regarding the issue of accident, the Arbitrator finds that Petitioner suffered an accidental injury on February 4th, 2015. The Respondent contends that this may be a repetitive trauma case, but the testimony of Petitioner is straight forward and credible. There are no records of back pain prior to February 4th, 2015. Further, Petitioner filled out an accident report less than 48 hours following the injury.

Issue (F): Is Petitioner's Current Condition of Ill-Being Causally Related to the injury on 2/04/15

Regarding the issue of causation, the Arbitrator finds that Petitioner's current condition of ill-being is caused by the accident on 2/04/15. There are no records of any treatment for his back or complaints of back pain prior to the injury on 2/04/15. Petitioner testified that in the days, weeks, and months preceding the injury on 2/04/15, he had not been referred for x-rays, MRIs, or been referred to a specialist for back pain. (T. 12). Within two months of the injury, he had an x-ray, MRI and a referral to an orthopedic specialist. Petitioner did not miss work for any reason including back complaints prior to 2/05/15. (T. 9-10). Petitioner also testified that prior to 2/04/15, he never experienced the kind of pain he experienced since that day. (T. 42). He has sought continuous care since the accident. (T. 16). He has had constant pain since the accident. (T. 19). Dr. Joy opined on 3/06/15 that Mr. Fleming's pain was from "lifting" which "he does at work." (PX 3). Further, Dr. Kovalsky opined that Petitioner "was injured on February 4th. He was lifting and carrying and twisting, felt immediate pain in his back with radiation into his right buttock and thigh." (PX 4).

Issue (L): Is Petitioner entitled to TTD benefits

Regarding the issue of TTD, the Arbitrator finds that Petitioner is entitled to TTD benefits from 2/05/15 through the date of the hearing, except for one week when Petitioner worked light duty. Petitioner had work slips accounting for everyday since the injury. Therefore Petitioner is entitled to 21 weeks of TTD. The parties have stipulated to an AWW of $418.95, resulting in $279.44 in weekly TTD benefits. The Respondent is order to pay $5,868.24 representing $279.44 per week for 21 weeks.

Issue (M): Should Penalties or Fees be Imposed Upon Respondent

Regarding penalties, the Arbitrator finds that Petitioner was entitled to TTD benefits beginning on 2/05/15. The Respondent was aware of the accident on 2/06/15 based on the First Report of Injury filled out by Petitioner that day. The Respondent sent a letter to Petitioner's attorney on June 22, 2015, discussing their nonpayment of TTD benefits. However, by that time, the Respondent already had Dr. Joy's records of 3/06/15 wherein he opined that Petitioner's condition of ill-being was job-related. Petitioner sent those records to Respondent on June 3, 2015. (PX 8). Respondent's correspondence dated June 22, 2015, does not acknowledge Dr. Joy's causation opinion, which the Respondent had for at least 2.5 weeks. Instead, the Respondent contended that a lack of a narrative from Dr. Kovalsky warranted a denial of **all** TTD benefits, even during those periods Petitioner was kept off work by Dr. Joy, two months **before** Petitioner saw Dr. Kovalsky. Finally, Petitioner sent said narrative from Dr. Kovalsky the next day, June 23, 2015, and still the Respondent failed to pay any benefits. (PX 8). Petitioner is entitled to 21 weeks of TTD, beginning on 2/05/15. Respondent has failed to pay any TTD whatsoever to Petitioner. Section 19l penalties are in essence a late fee. Consequently, Section 19l penalties are owed in the amount of $4,410 reflecting the statutory penalty of $30.00 per day beginning 2/12/15 through the date of the hearing, 7/10/15, a period of 147 days. Further, the Arbitrator finds that Petitioner is entitled to Section 19k penalties in the amount of 50% of the outstanding TTD or $2,934.12.

Regarding fees pursuant to Section 16, for all of the reasons supporting the award of penalties above, the Arbitrator finds that the respondent shall pay attorney fees in the amount of 20% of the outstanding TTD, or $1,173.65.

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

Robert Rich,
Petitioner,
vs.

NO: 11WC 39406

Hi-Lo Building Restoration,
Respondent,

16IWCC0366

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 4, 2015, is hereby affirmed and adopted.

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

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

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

DATED: JUN 1 - 2016
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CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RICH, ROBERT
Employee/Petitioner

Case# **11WC039406**

HI-LO BUILDING RESTORATION
Employer/Respondent

16IWCC0366

On 5/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JEFFREY ALTER
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0507 RUSIN & MACIOROWSKI LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT RICH
Employee/Petitioner

v.

HI-LO BUILDING RESTORATION
Employer/Respondent

Case # **11** WC **39406**

Consolidated cases: _____

16IWCC0366

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

DISPUTED ISSUES

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

16IWCC0366

FINDINGS

On **9/15/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, the average weekly wage was $**1228.00**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Petitioner failed to meet his burden of proof on the issues of accident and causation. Accordingly, the claim for benefits is denied.

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

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

Signature of Arbitrator

4/30/15
Date

MAY 4 - 2015

16IWCC0366

FINDINGS OF FACT

The Petitioner has brought this claim alleging that he sustained injuries to his right shoulder as a result of a specific injury he sustained on September 15, 2011 while employed by Respondent. The principal or threshold issues presented at trial are whether the Petitioner sustained an accident arising out of and in the course of his employment and whether his right shoulder condition of ill-being was related to the alleged accident on September 15, 2011.

At the time of the alleged accident, the Petitioner was 39 years old. He had been employed by Respondent for several months. He was hired in June, 2011as a union laborer by the Respondent through Petitioner's union. Although medical records reflected Petitioner said he was laid off for approximately two years (see Rx4), Petitioner testified that prior to his employment for Respondent, he was employed on a highway construction job. Nevertheless, Petitioner did not have personal medical insurance prior to or after the alleged accident on September 15, 2011 as he had not secured enough time to be eligible for insurance under his union plan.

On September 15, 2011 the Respondent was performing masonry work on a two-story National Guard building in Kankakee, Illinois. Scaffolding was used for performing the work. Petitioner's job as a laborer was to provide the materials to the bricklayers and to move the scaffolding. The scaffolding would be moved up and down the building through a pulley-rope system. Petitioner claims that as he and a bricklayer were pulling the ropes to move the scaffolding on the pulley system, he injured his right shoulder. The alleged accident occurred towards the end of Petitioner's work shift. Petitioner did not say anything to anyone regarding the injury on September 15th. Petitioner testified that the symptoms in his right shoulder increased the evening of September 15th. He reported the accident to Respondent the following day.

Prior Medical History

It is undisputed that Petitioner had symptoms and received medical treatment for his right shoulder prior to the alleged accident (Rx1-Rx7). Petitioner testified that he was involved in two incidents in 2010, which resulted in an injury to his right shoulder.

Petitioner initially testified that he injured his right shoulder as a result of a motor vehicle accident in 2010. He later testified that he also was involved in an altercation which resulted in an injury to his right shoulder as well. Petitioner said that the altercation occurred prior to the motor vehicle accident in 2010.

Although the Petitioner described the altercation as a "scuffle", the medical evidence reflects the Petitioner sought treatment for his injuries at St. James Hospital on June 25, 2010 (Rx1). Contrary to Petitioner's labeling of the altercation as a "scuffle", he gave a history at St. James being hit in the head three times which resulted in a loss of consciousness with the third hit (Rx1). Petitioner did admit that he was hit in the head with a lead pipe.

The medical records from St. James reflect Petitioner needing to be evaluated for a potential head injury. This included undergoing a CT scan of the head and brain as well as an MRI of the brain (Rx1). Although the Petitioner did not have any specific complaints involving his shoulder, these medical records from St. James Hospital reflect complaints and injury involving his right hand (Rx1).

On May 31, 2011, Petitioner first sought treatment for his right shoulder condition. Petitioner sought treatment from his family doctor at OSFMG Cullom (Rx2). Petitioner gave a history of injury to his right shoulder

16IWCC0366

stemming from a motor vehicle accident the year prior. Petitioner complained that the pain was worsening. He also complained of numbness. Petitioner also complained that he works as a carpenter and was experiencing numbness in his arm at the end of the day (Rx2).

On June 16, 2011, Petitioner subsequently underwent an MRI of the right shoulder. Petitioner again gave a history at the time of the MRI of having right shoulder pain as a result of a motor vehicle accident the year prior (Rx3). The results of the MRI revealed evidence of a partial thickness tear of the infraspinatus and supraspinatus tendons superimposed on chronic tendinosis. There was also evidence of AC athrosis (Rx3).

On June 16, 2011, Petitioner also received treatment from Dr. Daniels at OSFMG Orthopedics (Rx3). Dr. Daniels noted that the MRI revealed evidence of a partial thickness tear of the infraspinatus tendon and a high grade partial thickness tear of the supraspinatus along with the evidence of chronic tendinosis. Dr. Daniels diagnosed the Petitioner with right shoulder pain, right shoulder AC arthrosis and right shoulder chronic tendinosis with impingement (Rx3). Dr. Daniels provided the Petitioner with a cortisone injection of the right shoulder (Rx3).

On June 27, 2011, Petitioner received follow up treatment for his shoulder complaints at OSFMG Orthopedics (Rx4). Petitioner now gave a history of injury to his right shoulder a year prior during an altercation. Petitioner gave a history that during the altercation his arm and shoulder was in a twisted position. Petitioner complained that the pain was progressively getting worse. He further complained of having difficulties sleeping, as well as pain into his hand. Petitioner also described his "hand is on fire." He further complained of his hand going numb. Petitioner described his pain level regarding his shoulder as 7/10 on a good day (Rx4).

On June 30, 2011, Petitioner was then treated by Dr. Sipe at OSFMG Orthopedics for his shoulder pain (Rx4). Petitioner gave Dr. Sipe a history of having pain since an injury one year prior due to an altercation. Petitioner stated that he had his arm twisted behind him during the altercation. He complained of pain at night along with pain with overhead use (Rx4). Petitioner complained of night pain and pain with activity (Rx4). Contrary to Petitioner's testimony regarding his employment at a highway construction job, Petitioner told Dr. Sipe he has been laid off from labor type jobs over the past two years (Rx4). Dr. Sipe provided a cortisone injection (Rx4). Petitioner then returned to OSFMG Orthopedics for a re-check of his shoulder on July 25, 2011 (Rx5). Petitioner stated that the injection did not provide any relief in pain. Petitioner stated that his pain level was 9/10. Petitioner again related his shoulder condition to an injury after getting into a fight (Rx5).

On July 26, 2011, Petitioner again received treatment at OSFMG Orthopedics for his chronic right shoulder pain (Rx6). Petitioner stated that though he had some improvement with the cortisone injection by Dr. Sipe, the pain was recurring (Rx6). Petitioner discussed his employment in construction. Petitioner stated that due to the current job market he did not want to stop his job at this time. Petitioner stated that he was hopeful of having a surgical procedure sometime this winter, but would like to keep working if possible. Petitioner asked whether he could have one additional cortisteroid injection (Rx6). Petitioner was given another cortisteroid injection. He was told to return in six to eight weeks if his symptoms persisted (Rx6).

On September 12, 2011, three days prior to the alleged accident, Petitioner received treatment from his family physician (Rx7). Although Petitioner was treated for a cough and ear pain, the record reflects that the Petitioner's active problem list included impingement syndrome, shoulder pain, AC arthritis and bursitis of the right shoulder (Rx7).

Medical Treatment post accident date of September 15, 2011

Petitioner returned to Dr. Sipe for treatment on September 23, 2011(Px2). Petitioner stated that at the time of the alleged accident of September 15, 2011, he felt a pull and pop to his left shoulder. Petitioner believed that the pain was much different. He was having difficulty with activities of daily living and could not sleep on his affected side. Petitioner also said he had a new complaint of numbness and tingling shooting down his entire arm which started since his alleged accident (Px 2). X-rays of the shoulder on September 23rd did not reveal any acute fractures. The x-ray did reveal the AC joint arthrosis (Px2). An EMG, as well as a repeat MRI was ordered on September 23rd (Px2).

Electrical studies were performed on October 27, 2011. Results were negative (Px2).

Petitioner also underwent the repeat MRI on October 24, 2011. The MRI was compared with the prior MRI of June 16, 2011 (Rx8, Rx3, Px 2). The MRI on October 24, 2011 did not reveal any changes as it involved the partial thickness tears of the infraspinatus and supraspinatus tendons or associated tendinosis. It was the radiologist's impression that there was no new injury (Rx8, Px2).

Petitioner then returned to Dr. Sipe's office on November 11, 2011(Rx9, Px2). Results of the electrical studies and the repeat MRI were noted. Petitioner's diagnosis on November 11, 2011 did not change from his diagnosis prior to the alleged accident on September 15, 2011. Petitioner was scheduled for arthroscopic surgery of the right shoulder. (Rx9, PX2).

Dr. Sipe performed arthroscopic shoulder surgery on December 6, 2011 (Px1). Dr. Sipes's pre-operative diagnosis was of right shoulder pain, right shoulder partial rotator cuff tear, right shoulder impingement syndrome and right shoulder acromial clavicular degenerative joint disease (Px1). During the surgery, Dr. Sipe also found evidence of a SLAP tear. Dr. Sipe noted that the MRI did not show evidence of a new injury from the prior MRI (Px1). Dr. Sipe further noted that as Petitioner did not improve with conservative therapy, he wished to proceed with arthroscopic evaluation and management (Px1). During the surgery, Dr. Sipe noted that there was degenerative fraying of the labrum, which was debrided along with the rotator cuff. Dr. Sipe also noted degenerative changes throughout the shoulder compartments (Px1).

Post-operatively, Petitioner received follow up treatment from Dr. Sipe. On December 19, 2011. Petitioner was referred for occupational therapy (Px2). Petitioner then received therapy in the rehab department at St. James Medical Center (see, Px3).

Petitioner was released from treatment by Dr. Sipe on January 17, 2012. At that time, Petitioner complained of some stiffness, although the pain was improving. He denied any numbness or tingling. Petitioner was released to regular duty work at that time (Px2).

Medical Expert Testimony

Medical expert testimony was provided as part of this litigation. Petitioner's treating physician, Dr. Sipe, did not provide expert testimony. Petitioner's attorney sent the Petitioner for an independent medical evaluation with Dr. Coe, an occupational medicine specialist.

Petitioner was evaluated by Dr. Coe on April 3, 2012 (Px4, Px5). Dr. Coe opined that Petitioner sustained an injury at work on September 15, 2011 (Px4). He claimed that the Petitioner had sustained a glenoid labral tear, as well as an aggravation of his pre-existing rotator cuff tears and acromial clavicular degenerative joint disease (Px4).

Dr. Coe testified on cross-examination that the MRIs prior and subsequent to the Petitioner's alleged accident on September 15, 2011 did not reveal any evidence of new injury (Px5, p.60). Dr. Coe went on to opine that the significant change was an avulsion tear of the glenoid labrum (Px5, p.60).

Dr. Coe did not obtain a history of the Petitioner being in an altercation at the time of his evaluation (Px4, Px5, p.65). Dr. Coe did admit that it is possible that Petitioner could have sustained a labral tear as he had got his arm twisted during the altercation (Px5, p.67). Dr. Coe also agreed that even though the Petitioner was not diagnosed with a labral tear prior to the surgery, it is not unusual for a labral tear not to be visible on MRI (Px5, p.67). Dr. Coe further admitted that there is no clinical testing that is entirely reliable to diagnose a labral tear. He agreed the tear was not discovered until the time of his surgery (Px5, p.68).

Respondent had the Petitioner evaluated by Dr. Lieber, a board certified orthopedist, on January 24, 2012 (Rx10, Rx11). Based upon his examination of the medical records and the radiological information, Dr. Lieber was of the opinion that there was not a causal relationship between Petitioner's alleged work injury on September 15, 2011 and his shoulder condition (Rx 10). Dr. Lieber opined that there was not any abnormality within the Petitioner's right shoulder due to the work injury (Rx10). Dr. Lieber further opined that the SLAP tear of the labrum was degenerative in nature and not associated with the alleged work injury on September 15, 2011 (Px10). Dr. Lieber was further of the opinion that the alleged work injury on September 15, 2011 did not aggravate the Petitioner's pre-existing shoulder condition (Px10). Dr. Lieber testified consistent with the opinions expressed in his medical report (Rx11, p.20-22). In regards to the labral tear, Dr. Lieber opined that the tear was degenerative. He also opined that based upon the MRI, Petitioner had a degenerative shoulder and the labral tear was part of the problem (Rx11, p.18-19).

CONCLUSIONS OF LAW

1. With regard to the issues of accident and causation, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. In support of this finding, the Arbitrator relies heavily on the medical evidence, which clearly shows the Petitioner was suffering from a pre-existing, degenerative condition. In 2010, the Petitioner was in an altercation which, according to his history to medical providers, resulted in an injury to his shoulder. Petitioner specifically noted that he injured his shoulder when his arm was twisted behind his back. To compound this injury in the altercation, Petitioner was also involved in a motor vehicle accident in 2010 causing further damage to his shoulder. The facts further show the Petitioner complained of a progressive worsening in his pain symptoms 3 days prior to his alleged accident date. The medical evidence also shows Petitioner's pain complaints progressed between treatment in May, 2011 and July, 2011. Specifically, Petitioner described his pain level as 7/10 on a good day on June 27, 2011. By July 25, 2011, Petitioner's pain level was 9/10. This was after the Petitioner had undergone a cortisone injection. The medical evidence also shows the Petitioner having difficulty with various activities prior to the alleged accident on September 15, 2011. He complained of night pain along with difficulty sleeping. He further has symptoms of pain with overhead use and any activity including the shoulder. The medical evidence is also undisputed that Petitioner's MRI on June 16, 2011 and prior to the accident, as well Petitioner's clinical examinations revealed evidence of rotator cuff tears and shoulder pathology. The MRI revealed evidence of partial thickness tears of the tendons super imposed on chronic tendinosis. There was also evidence of AC joint arthrosis observed on the MRI. The evidence indicates

discussions regarding future surgery during treatment on July 26, 2011. It is clear that the injection performed by Dr. Sipe had not relieved or improved his symptoms and the Petitioner knew he was going to need surgery. However, Petitioner advised Dr. Sipe that he did not wish to stop working due to the job market, if possible, and would hopefully have surgery in winter. In the meantime, the Petitioner asked for an additional injection to continue working.

The medical evidence also fails to demonstrate Petitioner suffered any additional injury to his right shoulder due to the alleged accident on September 15, 2011. Despite Petitioner's testimony as to what he experienced at the time of the alleged accident, the medical evidence fails to demonstrate any additional injury. This is observed through the repeat MRI which shows no change in Petitioner's shoulder pathology when compared with the prior MRI and the notation by the radiologist that there was "no new injury." Petitioner's claim that he had developed a new complaint of numbness and tingling into his arm after the alleged accident is refuted by the medical evidence reflecting the same complaints prior to September 15th.

Finally, Petitioner's diagnosis did not change after the alleged accident on September 15, 2011. Further, while it is true that Dr. Sipe found evidence of a labral tear during shoulder surgery, the medical evidence, as well as the medical expert testimony and medical opinions disprove any acute trauma. Specifically, Dr. Sipe's operative report reflects that the labral tear was degenerative. Dr. Lieber confirmed that the labral tear was degenerative. Moreover, Dr. Coe, Petitioner's medical expert agreed that a labral tear may not be visible on MRI. Dr. Coe further agreed that there is no reliable clinical testing to diagnose a labral tear. Dr. Coe further agreed that the mechanism of injury to Petitioner's shoulder during the altercation could have caused a labral tear.

This medical evidence, along with issues involving Petitioner's credibility regarding the accident, requires the denial of this claim. The medical evidence does not support Petitioner's testimony as to the change in his shoulder condition after this accident. Petitioner's credibility is also suspect as the evidence clearly shows he needed further treatment for his shoulder prior to the alleged accident, but did not have personal medical insurance to utilize for treatment. Petitioner also was not eligible for medical insurance despite his employment for Respondent due to his union's eligibility requirements.

Based on all the above, the Arbitrator concludes that the Petitioner failed to prove that he sustained an accident on September 15, 2011 or that his condition of ill-being is related to the alleged accident from that date.

2. Based upon the findings above, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ralph Burns,
Petitioner,

vs.

NO: 13WC 27012

16IWCC0367

Legendary Baking,
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 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 March 16, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $67,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 1 - 2016
o052516
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BURNS, RALPH
Employee/Petitioner

Case# **13WC027012**

LEGENDARY BAKING
Employer/Respondent

16IWCC0367

On 3/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
SCOTT GOLDSTEIN
162 W GRAND AVE
CHICAGO, IL 60654

2542 BRYCE DOWNEY & LENKOV
RICH LENKOV
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

16IWCC0367

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

Ralph Burns
Employee/Petitioner

v.

Legendary Baking
Employer/Respondent

Case # **13** WC **27012**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen Friedman**, Arbitrator of the Commission, in the city of **Chicago**, on **March 6, 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 **July 31, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$44,720.00**; the average weekly wage was **$860.00**.

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

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

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

Respondent shall be given a credit of **$4,779.31** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$4,779.31**.

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 $573.33/week for 7 6/7 weeks, commencing July 31, 2013 through September 23, 2013, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$4,779.31** for TTD.

Respondent shall pay Petitioner permanent partial disability benefits of $516.00/week for 130 weeks, because the injuries sustained caused the disfigurement of the left leg, both hands and arms and the face, as provided in Section 8(c) of the Act.

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

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

Signature of Arbitrator

March 16, 2015
Date

MAR 16 2015

Statement of Facts

At the close of proofs, on motion of the Petitioner and without objection from Respondent, the Application for Adjustment of Claim was amended to change the date of accident from July 30, 2013 to July 31, 2013.

Petitioner Ralph Burns was employed by Respondent Legendary Baking as maintenance mechanic. Petitioner testified that on July 31, 2013 he started the oven and it blew up. He was wearing work pants and a long sleeved work shirt. He was wearing a hair net with an elastic headband. Petitioner testified that he suffered burns to his face, ears, lips, both hands, left arm and left leg.

Petitioner testified that he was taken by ambulance to South Suburban Hospital. He testified he was treated and released. The ambulance report records second degree burns to both hands and third degree burns to both elbows and the nose (Px 1). The South Shore Hospital emergency room record notes burns to both hands and his face as well as his legs (Px 2).The record finds burns to the nose, eyebrows and eye lashes are gone, and second and third degree burns to the fingers and palms. The left hand was worse and will require debridement. Burns were 13.5-14% of surface area (Px 2, pg 28-29).

Petitioner testified that he was sent for follow up at the University Of Chicago Hospital. He was admitted and was treated for his burns through a discharge date of August 9, 2013. The University of Chicago records were admitted as Petitioner's Exhibit 3. The records contain photographic evidence of the areas of burning (Px 3, pg 100). Petitioner was treated with biobrane, a wrapping infused with ointment, ongoing debridements and wound care. He also had hydrotherapy and occupational therapy to maintain range of motion in his wrists due to concerns that the burn scarring would result in contractures (Px 3, pg 104, 112). Petitioner was discharged with a further prescription for silvadene (Px 3, Pg 1).

Petitioner testified that following his discharge from the hospital he has had follow up visits. He used silvadene cream for about two weeks. Petitioner returned to work for the Respondent. He is doing the same job and earning the same pay. He last saw the doctor on June 20, 2014 and is to see him for follow up in a year. He is no longer using any cream for his burns. He is not taking any prescription medication.

The Arbitrator observed the Petitioner's scarring. On Petitioner's left lower leg he has several round darkened areas with some roughening and dryness of the skin. Petitioner's right hand is noticeably darkened to the wrist with some mottling coloration. There are round areas of darkened scarring on the right forearm. Petitioner's left hand is also noticeable darkened with mottled coloration. In addition, Petitioner has areas of loss of pigmentation on the little, ring and middle fingers of the left hand. The Petitioner has several round darkened

areas of scarring on the left forearm. Petitioner also has a darkened band across his forehead caused by the elastic band of the hairnet he was wearing.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Petitioner's unrebutted testimony was that on July 31, 2013 he was injured when the oven exploded. The ambulance report and medical records substantiate his testimony. The medical records also corroborate Petitioner's testimony as to the extent and location of the burns he received in the accident. Based upon Petitioner's credible testimony and the medical records admitted, the Arbitrator finds that, as a result of the accidental injuries sustained on July 31, 2013, Petitioner suffered burns to his left leg, both hands and arms and his face which caused the burn scarring that the Arbitrator observed.

In support of the Arbitrator's decision with respect to (L) Nature and Extent, the Arbitrator finds as follows:

Petitioner did not testify to any ongoing disability as a result of the accidental injuries sustained on July 31, 2013, nor do the medical records submitted support a finding of specific loss of use. The Arbitrator did personally observe the Petitioner's areas of burn scarring and observed serious and permanent disfigurement to the left lower leg, both hands and forearms and to Petitioner's face.

Based upon the Petitioner's testimony, the medical records reviewed and the Arbitrator's observation of the Petitioner's condition, the Arbitrator finds that Petitioner is entitled to 130 weeks of compensation for the serious and permanent disfigurement to the left lower leg, both hands and arms and the face.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Teresa White,
Petitioner,
vs.

NO: 14WC 30981

CTA,
Respondent,

16IWCC0368

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 27, 2015, is hereby affirmed and adopted.

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

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

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

DATED: JUN 1 - 2016
o052516
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WHITE, TERESA
Employee/Petitioner

Case# **14WC030981**

CTA
Employer/Respondent

16IWCC0368

On 4/27/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0515 CTA
ANDRA ZECHMAN
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

16IWCC0368

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Teresa White
Employee/Petitioner

v.

CTA
Employer/Respondent

Case # **14** WC **30981**

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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **February 25, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 5, 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 **$48,407.12**; the average weekly wage was **$932.06**.

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.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $621.37/week for 5 and 2/7 weeks, commencing September 6, 2014 through October 12, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical services of $4,089.00 under Sections 8(a) and 8.2 of the Act for the following unpaid medical bills: City of Chicago EMS - $1,034.00, St. Anthony Emergency Services - $250.00, St. Anthony Hospital - $1,811.00, Midwest Imaging Professionals - $114.00, and Peoples Medical Center - $880.00 pursuant to the fee schedule or prior agreement whichever is less, pursuant to the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $559.24/week for 10 weeks, because the injuries sustained caused the Petitioner 2% loss of the man as a whole, as provided in Section 8(e) of the Act.

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

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

Richard L. Simpson
Signature of Arbitrator

April 24, 2015
Date

APR 27 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Teresa White,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 30981**
	)	
CTA,	)	
	)	
Respondent.	)	**16IWCC0368**
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on September 5, 2014, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of this dispute within the time limits stated in the Act. They further agree that in the year preceding the injury the Petitioner's earnings were $48,407.12, and her average weekly wage, calculated pursuant to Section 10 of the Act, was $932.06.

At issue in this hearing is as follows: (1) Did Petitioner sustain an accidental injury on that date, that arose out of and in the course of the employment; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Is the Respondent liable for the unpaid medical bills listed in the Medical Bills statement attached to Arbitrator's Exhibit #1; (4) Is the Petitioner entitled to TTD from September 6, 2014 through October 12, 2014; (5) What is the nature and extent of the injury; and (6) Is the Petitioner entitled to attorney's fees and penalties.

STATEMENT OF FACTS

On September 5, 2014 the Petitioner was a 52 year old bus operator employed by the Respondent since November 16,1998. She is right hand dominant. At the time of accident, she weighed about 319 pounds.

On September 5, 2014, Petitioner went to work as a bus operator in the early morning. She went to get a bus and began to perform her routine pre-pullout check, which included pulling the mirrors out on the bus. Adjusting the right-side mirror involved standing on the platform in the front doorway of the bus and pulling the mirror out with her right arm. The mirrors had to be

pulled out because they were pushed in overnight in order to clean the bus. Petitioner testified that she always performs a pre-pullout check before operating the bus and that she always checks the mirrors the same way.

Petitioner testified that, as she was pulling on the right mirror with her right hand on the morning of September 5, 2014, she lost her grip and lost her balance. She made an attempt to catch herself, but she fell from the approximately one-and-a-half-foot-tall platform floor of the bus to the concrete ground. She landed on her right side, including her right buttock, hip, elbow, and shoulder.

There was a camera on the bus which recorded the incident and Respondent submitted a video recording of the accident from the morning of September 5, 2014, which was numbered Respondent's Exhibit #1. The video depicts the Petitioner, standing inside the bus, going down the stairs out of the bus around the front, then returning inside the bus. After pulling her hair into a pony tail the Petitioner walks to the door entrance of the bus, grabs on to the rail with her left hand and leans outside the door using her right arm to adjust the mirror. While she is pulling on the mirror she either lets go of the rail or loses her grip falling to the side, out of the bus. Her hand appears to try to grab the door as she is falling out of the bus but she is not able to stop the fall. The Petitioner landed on her right side on the floor. (RX 1) Petitioner stayed lying on the floor on her right side. Occasionally she waives her left arm like she is pushing someone away.

Petitioner testified that she immediately felt sharp, excruciating pain in her neck, extending down to her right shoulder and elbow. Another bus operator nearby saw Petitioner on the ground and notified a manager employed by Respondent, who then called an ambulance. After her initial impact with the ground, Petitioner stated that she stayed lying down in a half-fetal position for 25-30 minutes.

On the day of the accident, Petitioner was taken by ambulance to St. Anthony Hospital and treated by Dr. Kaleem Malik. Petitioner reported slipping and falling onto her right side while trying to adjust the side mirror on the Respondent's bus. Upon examination, Petitioner's right shoulder showed no signs of swelling, hematoma, erythema, ecchymosis, warmth, or muscle atrophy. Her right scapula, acromioclavicular joint, and humerus were tender to palpation. She had pain with active and passive range of motion testing. X-rays showed no fracture in the right humerus or shoulder. There was minimal fragmentation in the right acromion region that may have been related to chronic injury or spurring. The diagnosis was moderate right shoulder strain, exacerbated by movement. Petitioner was discharged with a prescription for Tramadol and instructed to follow up with an orthopedist if the pain did not improve. (PX1)

Later that day, Petitioner was examined by Dr. Boris Kusnetzow at People's Medical Center. She reported injuring her right neck and shoulder after falling onto concrete from the bus platform while adjusting the right mirror. He diagnosed Petitioner with a cervical spine and lumbar spine sprain, a right shoulder contusion with a sprain, and a right elbow contusion with an abrasion. He instructed Petitioner to remain off of work completely. (PX2)

On September 12, 2014, Petitioner followed up with Dr. Kusnetzow. She reported that the pain and stiffness in her neck was worse. Upon examination, Petitioner had stiffness in her

neck and spasms in her right shoulder, as well as bruising on the right hip. Dr. Kusnetzow recommended that Petitioner remain off of work and begin physical therapy. (PX 2)

Petitioner saw Dr. Kusnetzow again on September 22, 2014. She reported that the strains in her cervical spine and lumbar spine were worse. She was kept off of work. (PX 2)

On October 6, 2014, Dr. Kusnetzow again examined Petitioner, noting spasms in her neck. Petitioner was still unable to sit or bend or steer. Dr. Kusnetzow continued to recommend physical therapy. (PX 2)

Petitioner last treated with Dr. Kusnetzow on October 9, 2014. Upon examination, Petitioner was still experiencing frozen right shoulder and elbow, tenderness and spasms along the cervical and lumbar spine, and bruising on the right hip. The diagnoses were right shoulder sprain, right elbow sprain, cervical spine and lumbar spine sprains, and right hip contusion. Dr. Kusnetzow released Petitioner to return to work full duty as of October 13, 2014 and prescribed her a muscle relaxant and pain medication. (PX 2)

At the time of hearing, Petitioner testified that she was still in pain on October 9, 2014, but she asked to be released back to work because she needed income. She did return to work at full duty on October 13, 2014.

Petitioner testified that, prior to September 5, 2014; she was not having any problems with her neck, right shoulder, or right elbow. She currently gets stiffness and pain when she tries to perform any heavy lifting. She lives on the third floor of a building and has her son carry up groceries. She also has her son lift heavy pans for her when she cooks. Prior to the accident, Petitioner used to perform these tasks on her own. Petitioner testified that her sleep is sometimes interrupted when she feels stiffness and pain in her neck. The pain gets worse when the weather gets colder. Petitioner takes over-the-counter medication for relief.

Petitioner testified that she gets sharp pain after driving a bus for Respondent, particularly when steering with her right arm. She is no longer able to pull out the mirrors on 60-foot CTA buses, and she asks for help at times with pulling out the mirrors on the 40-foot buses. When she tries too hard to pull on the mirror, she feels pain in her neck and right shoulder all day long. Petitioner testified that she was off of work completely from September 6, 2014 through October 12, 2014.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured

employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

To be compensable under the Act, the injury complained of must be one "arising out of and in the course of the employment". *820 ILCS 305/2*(West 1998). An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment, involving a causal connection between the employment and the accidental injury. *Parro v. Industrial Comm'n,* (1995) 167 Ill. 2d 385,393, 212 Ill. Dec. 537, 657 N.E. 2d 882.

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

In support of the Arbitrator's decision with respect to whether the Petitioner sustained an accidental injury that arose out of and in the course of the employment, the Arbitrator makes the following findings and conclusions of law:

Petitioner testified that she was required to check the mirrors on the bus during her pre-pullout check before she operated the bus every single time. She explained that the mirrors needed to be pulled out and adjusted because they were put in for cleaning every night. She lost her balance and fell as a result of pulling on the right mirror with her right hand. Petitioner was significantly overweight at the time of accident—approximately 319 pounds. She was unable to catch herself once she began to fall down.

The video submitted as Respondent's Exhibit 1 supports Petitioner's testimony, showing the Petitioner adjusting the right mirror, losing her balance, and then falling to the ground. Petitioner has worked as a bus operator with Respondent for about 17 years. Petitioner testified that she knew there were video cameras capturing footage of the bus at the time of her accident. At the time of hearing, no testimony was elicited on rebuttal to indicate that Petitioner's account of the accident is not credible.

The Arbitrator has reviewed the evidence and the testimony of the witness. The Arbitrator finds that Petitioner's accident did arise out of and in the course of her employment with Respondent.

In support of the Arbitrator's decision with respect to whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following findings and conclusions of law:

Petitioner testified that, prior to the accident on September 5, 2014, she was not having any problems with her neck, right shoulder, or right elbow. Immediately after she fell from the approximately one-and-a-half-foot-tall bus platform onto the concrete floor, Petitioner felt sharp pain in her neck, and right shoulder, and elbow. She was diagnosed that day with a cervical spine and lumbar spine sprain, a right shoulder contusion with a sprain, and a right elbow contusion with an abrasion. All of the medical records are consistent with this history.

The Arbitrator has had the opportunity to review the medical evidence and the testimony of the witness. The Arbitrator finds a causal connection between the work accident of September 5, 2014 and Petitioner's present condition of ill-being in the neck, right shoulder, and right elbow.

In support of the Arbitrator's decision with respect to whether the Respondent is liable for the unpaid medical bills listed in the Medical Bills statement attached to Arbitrator's Exhibit #1, the Arbitrator makes the following findings and conclusions of law:

The medical records reflect that Petitioner was taken via ambulance to the emergency room at Saint Anthony Hospital on the day of the accident, September 5, 2014. X-rays were taken of Petitioner's neck and shoulder. That same day, Petitioner treated with Dr. Boris Kusnetzow. She continued to follow up with him due to continued pain through her release to return to work full duty as of October 13, 2014. A-rays to make sure that no bones were broken as result of the fall from the bus to the concrete were not unreasonable.

The Arbitrator finds all of the medical treatment to be reasonable and necessary.

Petitioner presented unpaid medical bills as part of its Exhibit 3, a copy of which is attached to Arbitrator's Exhibit 1. Based on the Arbitrator's findings above, the bills are awarded as follows:

1. City of Chicago EMS – DOS 9/5/14, $1,034.00.
2. St. Anthony Emergency Services – DOS 9/5/14, $ 250.00.
3. St. Anthony Hospital—DOS 9/5/14, $1,811.00.
4. Midwest Imaging Professionals—DOS 9/5/14, $114.00.
5. Peoples Medical Center—DOS 8/14/14, $880.00.

In support of the Arbitrator's decision with respect to whether the Petitioner is entitled to TTD from September 6, 2014 through October 12, 2014, the Arbitrator makes the following findings and conclusions of law:

The Petitioner claims that she is entitled to TTD benefits for the period between September 6, 2014 and October 12, 2014, a period representing 5 and 2/7 weeks. Respondent claims that it does not owe any TTD benefits. The Arbitrator notes that Petitioner returned to work full duty on October 13, 2014. Petitioner was taken off of work the day of the accident by

her doctor after examining her, prior to that date, no doctor had released Petitioner to return to work with respect to her neck, right shoulder, and right elbow.

The Arbitrator has reviewed the evidence and finds Petitioner is entitled to TTD benefits for 5 and 2/7 weeks, representing the period between September 6, 2014 and October 12, 2014.

In support of the Arbitrator's decision with respect to whether What is the nature and extent of the injury, the Arbitrator makes the following findings and conclusions of law:

The Arbitrator adopts by reference all prior findings and conclusions into this Section without restating them herein. This claim arose after September 1, 2011, therefore the 5 factors for determining Permanent Partial Disability shall be applied here. The Arbitrator notes the five factors to determine Permanent Partial Disability are: 1) AMA Impairment Rating; 2) Occupation of the injured employee; 3) Age of the employee at the time of the injury; 4) Employee's future earning capacity; and 5) Evidence of disability corroborated by the treating medical records. No one factor shall be controlling but a written explanation is required if an award is greater than the AMA Impairment Rating. 820 ILCS 305/8.1b(b).

It is the claimant's burden to prove all aspects of his claim for benefits. This includes entitlement to Permanent Partial Disability.

1. ***AMA Impairment Rating***: Neither Petitioner nor Respondent presented an AMA Impairment Rating. Based on the failure to submit an AMA Impairment Rating the Arbitrator cannot consider this factor.

2. ***Occupation of the injured employee***: Petitioner was employed by Respondent as a bus driver. Petitioner was able to return to work, in her same job within 5 weeks and 2 days of her accident. Petitioner testified that he continues to work for Respondent in that capacity. Significant weight is given to this factor.

3. ***Age of the employee at the time of the injury***: Petitioner was 52 years old at the time of her accident. There is no evidence that Petitioner's age impacted her injury or created any permanent disability. The Arbitrator gives some weight to this factor.

4. ***Employee's future earning capacity***: Petitioner testified that she continues to work for the Respondent in her pre injury job. Petitioner did not testify to any diminution of her earnings since this accident or any affect on her ability to earn a living. There is no evidence of disability due to this factor, significant weight is given to this factor as well.

5. ***Evidence of disability corroborated by the treating medical records***: The Petitioner sustained a cervical spine and lumbar spine sprain, a right shoulder contusion with a sprain, and a right elbow contusion with an abrasion.

Petitioner testified that she currently gets stiffness and pain when she tries to perform any heavy lifting. Her sleep is sometimes interrupted when she feels stiffness and pain in her neck, and the pain gets worse when the weather gets colder. Petitioner feels pain after driving a bus particularly when steering with her right arm. She is no longer able to pull out the mirrors on 60-

foot CTA buses, and she asks for help at times with pulling out the mirrors on the 40-foot buses. When she tries too hard to pull on the mirror, she feels pain in her neck and right shoulder.

The determination of PPD is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all these factors, the Arbitrator concludes that Petitioner has sustained a 2% permanent loss of the person as a whole, or 10 weeks of PPD benefits.

In support of the Arbitrator's decision with respect to whether Is Petitioner entitled to attorney's fees and penalties, the Arbitrator makes the following findings and conclusions of law:

Given the facts presented in this case, and after considering the parties' motion and response, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner's injuries subsequent to September 5, 2014, arose out of her employment as alleged. Petitioner fell from the step of the bus, less than two feet. She did not lose consciousness, did not break any bones, had minor bruising and was able to move after the fall.

Respondent had video footage of the accident occurring while Petitioner was acting out of and in the course of her employment with Respondent. Respondent believed that Petitioner did not fall by accident, that her actions were voluntary. They disagreed with Petitioner's claim that she lost her balance and fell. They had what they believed was a legitimate defense to the Petitioner's claim. 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.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner temporary total disability benefits of $621.37/week for 5 and 2/7 weeks, commencing September 6, 2014 through October 12, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical services of $4,089.00 under Sections 8(a) and 8.2 of the Act for the following unpaid medical bills: City of Chicago EMS - $1,034.00, St. Anthony Emergency Services - $250.00, St. Anthony Hospital - $1,811.00, Midwest Imaging Professionals - $114.00, and Peoples Medical Center - $880.00 pursuant to the fee schedule or prior agreement whichever is less, pursuant to the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $559.24/week for 10 weeks, because the injuries sustained caused the Petitioner 2% loss of the man as a whole, as provided in Section 8(e) of the Act.

Deborah L. Simpson — April 24, 2015

Signature of Arbitrator — 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

DAVID FOY,

Petitioner,

vs.

NO: 14 WC 42463

NORTH AMERICAN LIGHTING,

16IWCC0369

Respondent.

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. At Hearing Respondent noted that it had paid $1,751.93 in Temporary Total Disability benefits to Petitioner.

2. Also at Hearing Respondent noted that it had made 10 advanced permanent partial disability payments of $394.18, totaling $3,941.80.

3. Petitioner was employed as a Material Handler for Respondent.

4. On March 9, 2014 he was moving products to the assembly line in order to assemble lamps. While moving a stack of totes, he turned and heard a pop in his left knee. He felt immediate pain.

5. After x-rays and an MRI Petitioner was diagnosed with a meniscus tear. Surgery was performed.

16IWCC0369

6. On July 24, 2014 Dr. Madsen opined that Petitioner had reached maximum medical improvement with relation to his left knee. He opined that Petitioner had a 7% deficit of his left lower extremity at the knee.

7. Petitioner then went to rehabilitation, and was eventually returned to light duty, then full duty. Soon he stated that he felt fine at work. However, he did testify to having difficulty walking the longer he walks. He also has difficulty kneeling, walking up stairs and climbing ladders at work.

The Commission awards Petitioner Temporary total disability in the amount of $1,751.93 per the parties' stipulation.

The Commission awards Respondent credit for the temporary total disability payments it has made in the amount of $1,751.93.

The Commission also awards Respondent credit for ten permanent partial disability payments made in the amount of $394.18 each, for a total credit of $3,941.80.

The Commission strikes the Arbitrator's statement giving no weight to the impairment rating as set forth in §8.1b of the Act. After factoring the impairment rating provided in evidence, the Commission finds that the 15% loss of use of Petitioner's left leg as awarded by the Arbitrator is appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $394.18 per week for a period of 32.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused Petitioner a 15% loss of use of his left leg.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $12,800.00. 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: JUN 3 - 2016
O: 4/7/16
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FOY, DAVID
Employee/Petitioner

Case# **14WC042463**
14WC042464

NORTH AMERICAN LIGHTING
Employer/Respondent

16IWCC0369

On 9/29/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0157 ASHER & SMITH
DREW P GRIFFIN
1119 N MAIN ST PO BOX 340
PARIS, IL 61944

0445 RODDY LAW LTD
STEPHEN A CARTER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

16IWCC0369

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

David Foy
Employee/Petitioner

v.

North American Lighting
Employer/Respondent

Case # **14** WC **42463**

Consolidated cases: **14 WC 42464**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **August 14, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 9, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**34,162.44**; the average weekly wage was $**656.97**.

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

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

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

Respondent shall be given a credit of $**1751.93** for TTD, $ for TPD, $ for maintenance, and $3941.80 for PPD advance, for a total credit of $5693.73.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $394.18 /week for 32.25 weeks because the injury sustained caused 15% loss of use of left leg, as provided in Section 8(e)(12) of the Act.

Respondent is not entitled to any credit under Section 8 (e) 17 for the Petitioner's prior settlement in the State of Florida.

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

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

D. Dylan McCarthy
Signature of Arbitrator

Sept. 22, 2015
Date

SEP 29 2015

FINDINGS OF FACT:

The parties in this matter stipulated to the following: that on March 9, 2014, Petitioner and Respondent were operating under the Illinois Workers' Compensation Act and that their relationship was one of employee and employer; that on March 9, 2014, the Petitioner sustained accidental injuries that arose out of and in the course of his employment; that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act; and that the Petitioner's current condition of ill-being is causally connected to the injury Petitioner sustained. The parties further agreed that they believe medical bills related to this injury have been paid; however, Petitioner was unsure whether he was aware of all outstanding medical bills. As such, the parties agreed that Respondent would pay any unpaid medical bills for treatment of this injury that may surface promptly upon presentation to the Respondent. This case was tried by consolidation with 14 WC 42464. As the Arbitrator stated at trial, the Petitioner's exhibits would be and have been renumbered to reflect the fact that one set of exhibits were used for both claims. The contested issues in this claim are nature and extent and whether the Respondent is entitled to any credit for a prior settlement received by the Petitioner in the State of Florida.

The Petitioner, David Foy (hereinafter "Petitioner"), testified that he had been an employee of Respondent since approximately November 2013. On March 9, 2014, Petitioner was an employee of the Respondent. His job description was that of "material handler." Respondent's company primarily produces lights, including headlights for automobiles. Petitioner testified that his job as material handler required him to transport various types of product necessary to the manufacturing process to various parts of Respondent's facility. Petitioner testified that he would transport this product with the aid of what he referred to as "rollers." From Petitioner's testimony, it seems that a roller is akin to some form of handcart: a sort of platform on wheels upon which product could be loaded and then pushed by an employee. Petitioner testified that he did not operate a forklift to move the product—he actually had to load the product onto the roller and then use his own physical capabilities to move the product. Petitioner currently is still an employee of Respondent, and he continues to work as a material handler.

Petitioner testified that on March 9, 2014, as he was bending down and twisting to pick up more product to load onto the roller, he felt something pop and pull in his left leg, specifically his left knee. Petitioner explained that this sensation was equivalent to what he imagined it would be like to be hit in the knee with a sledgehammer. Petitioner testified that the pain was immediate and severe. After completing an accident report, Petitioner went to the emergency room at Terre Haute Regional Hospital in Terre Haute, Indiana, to be treated for the injury.

After his trip to the emergency room, on March 13, 2014, Petitioner had his first appointment with Dr. Kurt R. E. Madsen. (PX 7) According to his report, Dr. Madsen examined the CT scan that had previously been performed, which he indicated showed a posterior cruciate ligament tear. (PX 7) Dr. Madsen gave Petitioner a script for an MRI. (PX 7) Dr. Madsen did allow the Petitioner to return to work, but restricted him to clerical duty only. (PX 7)

The MRI, done on March 26, 2014, showed osteoarthritic disease of the knee joint, articular cartilage degeneration, tears of both the medial and lateral menisci and a strain or tear of the anterior cruciate ligament. (PX 9)

On March 27, 2014, Petitioner had his second appointment with Dr. Madsen. (PX 6) At this appointment, Dr. Madsen's report states that Petitioner complained of constant pain, which had increased in intensity since his previous visit. (PX 6) Dr. Madsen reviewed the MRI that he had prescribed and noted that it showed a medial tear as well as loose body post-traumatic. (PX 6) Dr. Madsen indicated that Petitioner needed to be authorized for a left knee arthroscopy. (PX 6) Dr. Madsen allowed Petitioner to return to work, but he continued to restrict Petitioner to clerical duty work only. (PX 6)

Dr. Kurt Madsen performed the left knee arthroscopy on April 21, 2014. (PX 8) Dr. Madsen's postoperative diagnosis of the Petitioner was as follows: a left knee medial meniscus tear, left knee chondromalacia patella and medial femoral condyle, left knee pathologic plica, and left knee degenerative lateral meniscus tear. (PX 8) As of the date of surgery, Petitioner was ordered off work until released by a physician.

After the operation, Petitioner followed up with Dr. Madsen on May 1, 2014. (PX 5) At this follow-up, Dr. Madsen's report indicates that Petitioner told Dr. Madsen that he had constant pain in the knee. (PX 5) In addition to the pain, Petitioner explained to the doctor that he had some numbness in his toes when his leg was not elevated. (PX 5) Dr. Madsen ordered that the Petitioner was to begin physical therapy and that he was to continue to be off duty until subsequently cleared by a physician. (PX 5)

On May 15, 2014, Petitioner again saw Dr. Madsen. (PX 4) According to Dr. Madsen's report, Petitioner continued to complain to him of intermittent pain, and he also stated that he had been performing his physical therapy, icing, and elevating his knee. (PX 4) Petitioner explained to Dr. Madsen that he was still having some swelling and would hear a clicking sound when he would bend his knee. (PX 4) Dr. Madsen noted mild swelling on the knee, ordered him to continue physical therapy, and continued to restrict him from returning to work until cleared by a physician. (PX 4)

At Petitioner's appointment with Dr. Madsen on May 29, 2014, Petitioner complained to Dr. Madsen of constant sore pain in his left knee, and Dr. Madsen's report shows that Petitioner indicated that this pain is elevated during the night. (PX 3) In his report, Dr. Madsen noted swelling in Petitioner's left knee, and the knee was aspirated and injected. (PX 3) Dr. Madsen extended the order for physical therapy, and he allowed the patient to continue light duty at work, which he had commenced previously on May 22, 2014. (PX 3)

When Petitioner followed-up with Dr. Madsen on June 26, 2014, Petitioner continued to complain of intermittent pain to Dr. Madsen, which he maintained was worse at night. (PX 2) Dr. Madsen noted in his report that Petitioner was still experiencing mild swelling in his left knee. (PX 2) However, Dr. Madsen decreased Petitioner's work restrictions and allowed him to return to work, eight-hour days with 10-minute breaks as needed to ice his knee. (PX 2)

The last time Petitioner saw Dr. Madsen for this injury was on July 25, 2014. (PX 1) At this last meeting, Petitioner explained to Dr. Madsen that he walks a significant amount of miles as a part of his job responsibilities. (PX 1) Petitioner also complained to Dr. Madsen of intermittent, achy, popping pain in his left knee that would vary in severity. (PX 1) Petitioner said that he still had some swelling that he would treat with ice when needed. (PX 1) The doctor's examination showed minimal effusion and normal flexion and extension. He was continued on full duty work, and declared to be at maximum medical improvement. Dr. Madsen reported the Petitioner had a 7 % disability to the knee pursuant to the AMA Guides, 6th Edition, but provided no basis for his conclusions. At that time the Petitioner complained of increasing pain in the right knee, and requested treatment. (Id)

After his last appointment with Dr. Madsen, Petitioner returned to work and continued in his full-duty capacity. At the hearing, Petitioner testified that it took him awhile to get back to full strength, but that now his left knee felt fine. He went on to say that it "wore out" and was painful when he walked. He said stairs and ladders were problematic, and that he had to move the knee around when he was sitting. Finally, he said the knee did hurt him every day.

Prior to the accident, the Petitioner testified that he had injured the left knee in the State of Florida. He said he had surgery, but that his knee returned to normal and he felt good.

Medical records from the Florida injury were admitted into evidence. They show treatment by Dr. Boneberger for both knees between February 18, 2010 and November 12 of the same year. (RX 7) Surgery was apparently performed on June 14, 2010, but the operative report was not offered into evidence. Dr. Boneberger's first post op note of June 18, 2010 states that he performed an arthroscopic surgery with a partial medial menisectomy. He said the surgery was uneventful. Following physical therapy, the last physician note of November 12 showed the Petitioner complaining of mild residual pain. His exam showed a normal range of motion of 0-135 degrees in both knees. In addition to the medial tear, the doctor noted Grade 4 chondromalacia of the medial femoral condyle. The Petitioner was not given any work restrictions. The doctor assigned him an impairment rating of 3 % of the left knee without any reference as to how that percentage was calculated.

Respondent offered additional records from Florida, which were admitted. The records were offered in connection with a claimed credit, and they are summarized in the conclusions of law.

CONCLUSIONS OF LAW:

Beyond disputing the nature and extent of the injury, Respondent also argues that it is entitled to a credit against whatever award the Arbitrator may order in this matter. This argument is based on the allegation that Petitioner has previously had a permanent partial loss to the same member that Petitioner has injured in this matter and that Petitioner was compensated for this alleged loss in an out-of-state workers' compensation action in the state of Florida. In support of its argument, Respondent introduced into evidence some of Petitioner's medical records from the state of Florida from around 2010 (RX 7) and documentation related to a settlement Petitioner received in Florida that same year. (RX 16) Further, Respondent introduced into evidence the case of Keil v. Industrial Comm'n, 331 Ill.App.3d 478 (3d Dist. 2002) in support of its position. (RX 17)

The Illinois Workers' Compensation Act states as follows:

> "In computing the compensation to be paid to any employee who, before the accident for which he claims compensation, had before that time sustained an injury resulting in the loss by amputation or partial loss by amputation of any member, including hand, arm, thumb or fingers, leg, foot or any toes, such loss or partial loss of any such member shall be deducted from any award made for the subsequent injury. For the permanent loss of use or the permanent partial loss of use of any such member or the partial loss of sight of an eye, for which compensation has been paid, then such loss shall be taken into consideration and deducted from any award for the subsequent injury."

820 ILCS 305/8 (e)(17).

At trial, Petitioner testified that he had previously had a workers' compensation claim in Florida. Petitioner testified that his prior Florida workers' compensation matter concluded when a settlement had been reached. Petitioner testified that the net payment he received from settlement was approximately $30,000.00. However, Petitioner testified that he had no knowledge of what the settlement was based on, as well as the fact that he had no knowledge of exactly what he was being compensated for.

Respondent entered into evidence several documents, all with substantially the same heading: "State of Florida, Division of Administrative Hearings, Office of the Judges of Compensation Claims, Daytona Beach District Office." (RX 16) The Arbitrator believes that the total amount of Petitioner's prior out-of-state settlement can be ascertained from the document entitled, "Motion for Approval of Attorney's Fee and Allocation of Child Support Arrearage for Settlements under Section 440.20(11)(c),(d) and (e) Florida Statutes." That Motion recites a settlement amount of $35,000.00. (RX 16)

The Arbitrator finds this Motion extremely vague with regards to how it relates to Petitioner's Florida workers' compensation case and the partial permanent loss for which Respondent wants a credit. It makes no reference to any specific work-related injury; it does not discuss any injured body part(s) or the extent of any injury thereto; it does not indicate how the settlement amount is compensation for any loss experienced by Petitioner. In short, this Motion contains none of the type of information that a settlement contract or decision from this State for a workers' compensation claim would contain. What's more, this document is styled as a motion, and it appears only to seek court approval of an attorney's fee and some amount of funds related to "child support arrearage allocation." (RX 16)

The only Florida document presented by the Respondent that is an order, "Order Under Section 440.201(11)(c),(d),(e). Florida Statues. (2003)" appears to simply approve the attorney's fee and "child support arrearage allocation" requested in the aforementioned Motion. (RX 16) The Order does not actually approve any settlement. It does not discuss any injury to the any part of the Petitioner's body and the subsequent loss Petitioner suffered. It does not explain what link there may be between the settlement that the parties had entered into independently (that apparently is not subject to court approval in Florida) and any loss that may have been sustained by the Petitioner as a result of his work injury.

The Arbitrator finds that none of these court documents from Florida indicate the type of permanent partial loss sustained by the Petitioner or the extent of whatever that loss might be. In addition, these documents do not explain if or how the compensation provided to Petitioner under this Florida settlement was compensation for any partial loss of any member of the Petitioner's body that was a result of an injury compensable under the workers' compensation laws in the state of Florida.

The respondent points to the case of Keil v. Industrial Comm'n, 331 Ill.App.3d 478 (3d Dist. 2002). In Keil, the issue presented was whether the Commission had the authority under 8(e)(17) of the Illinois Workers' Compensation Act to grant a credit to an employer for a prior out-of-state award based on a loss for which the employee had previously been compensated. Keil, 331 Ill.App.3d at 479. The employee in that case, Gary Keil, prior to seeking benefits under the Illinois Workers' Compensation Act, had been awarded a 17-1/2 percent loss of use of his right leg in an Iowa workers' compensation case that resulted in him receiving $21,000.00 in compensation. Id.

Ultimately, the Keil court held that, "the Commission *may* grant credit for out-of-state awards pursuant to section 8(e)(17)." Id. at 481 (emphasis added). However, the court stated that, "the manner in which the amount of credit is determined is a factual matter for the Commission." Id. The court reasoned that this would allow for the requisite amount of flexibility for the Commission to address issues of whether to grant credit for out-of-state awards on a case-by-case basis, thereby helping to achieve the purpose of the Act. Id.

It is well settled that the party claiming the credit, in this case the Respondent, has the burden of proving entitlement to said credit. In the instant matter, there has been no evidence presented that indicated the nature and extent of any alleged prior permanent partial loss to a member of the

Petitioner, nor was there any evidence presented as to how whatever this alleged loss might have been was compensated.

Respondent wants the Arbitrator to look at the amount of the Florida settlement, examine a few select medical records, and then determine that, based on the dollar amount of settlement, Petitioner was compensated for some significant level of prior permanent partial loss for which Respondent should receive a credit. The Arbitrator cannot do this.

The Florida documents make no mention of any type of loss to Petitioner's member(s). Not only are the documents silent as to loss, but also the Arbitrator recognizes that there are many other factors that could have influenced the negotiation between the parties that allowed them to arrive at that settlement figure they did. For example, based on the fact that Petitioner ceased work for the employer as soon as the settlement was paid, the Arbitrator easily could presume that a significant portion of the settlement was not compensation for the loss Petitioner actually sustained, but rather for Petitioner ceasing his employment with that employer. Another example would be that a large portion of the compensation could be for medical expenses or what our state would call TTD. Again, this is all just speculation, but it underscores the Arbitrator's point: there is no way to ascertain based on the evidence whether the Petitioner had sustained a prior loss for which he was actually compensated.

Moreover, Petitioner testified that after being treated in Florida, his knees felt just fine. Petitioner stated that he was not experiencing any type of notable pain when he left Florida, and he further testified that his knee was free of any notable pain or disability when he commenced work for Respondent.

There is no way to know, based on the evidence, whether Petitioner suffered a prior permanent partial loss in Florida for which he was compensated, and, if so, what the extent of that loss or compensation for that loss was. Therefore, the arbitrator finds that, after appropriate consideration, no credit will be awarded to Respondent as it had requested in this matter.

With respect to the nature and extent of disability, the Arbitrator must consider the five factors set forth in Section 8.1b of the Act.

The only evidence offered by either party concerning the AMA 6th edition are the conclusory comments of Dr. Madsen in his note of July 25, 2014. As they are not accompanied by any explanation as to how the doctor arrived at the number, they are not given any weight by the Arbitrator.

The Petitioner was 47 years old when he was injured; he worked as a material handler, a job which required him to be on his feet moving materials around the plant with climbing and bending as needed and he was released to full duty work. The Arbitrator finds the age is rather neutral; the occupation favors the Petitioner's claim of disability and there was no showing of a future wage loss.

The Petitioner's condition, which the Respondent agreed was causally related to his accident, was described by Dr. Madsen in his note of July 25, 2014, described above.

Based upon all of the above factors, the Arbitrator awards the Petitioner 15 % loss of use of the left leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cortney Jones,

Petitioner,

vs.

NO: 13 WC 23829

16IWCC0370

USF Holland, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, prospective medical care, 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 Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 33 year old employee of Respondent, who described his job as a truck mechanic. Petitioner believed he started working for Respondent (in McCook) in May 2013. Petitioner was hired as a full time mechanic making $26.00 per hour (Respondent is a union shop). Petitioner started working for Respondent on the 6:00am to 2:30pm shift

Eventually Petitioner stated that he was put on 12:00 to 8:30am shift. Petitioner testified that 'If I am not mistaken' he was on that shift about a month. Prior to Respondent, Petitioner worked for UPS for 12 years as a mechanic. His profession has been as a union truck mechanic. Petitioner testified that he was working in that capacity on the day of the accident, working on diesel trucks. Petitioner stated that he worked with different hand tools; air hammers, air chisels, impact guns, tire impact guns. In his job he lifts, pushes and pulls. He indicated the heaviest weight he had to move around was about 100 pounds at most. Petitioner testified that he needed his hands and arms to perform his job. On the date of accident, July 12, 2013, Petitioner testified that he was installing a brake chamber and as he was tightening up a lock nut on it, his wrench slipped off and Petitioner hit his left elbow/(arm) against the tractor. Petitioner testified that at the time it occurred he noticed his left elbow; the nerve got irritated in his ring finger and little finger and got numb. Petitioner testified the event occurred at about 1:00am. Petitioner testified that he continued to work until between 6:00 and 6:30am and to that time he testified that his left elbow was getting worse and worse as he was working. Petitioner testified during that time his ring and little fingers were numb and he was starting to get swelling behind his left elbow. Petitioner viewed PX 5 and he identified it as a copy of the note he left letting Respondent know about the injury; he noted the date July 12, 2013. Petitioner read the note that indicated 'This is Cortney' and indicated tractor number 34 and Petitioner's employee number 34690. He noted it showed that he was installing brake chambers on tractor 19154 and his wrench slipped off the lock nut and he hit his left elbow on the frame. He noted he needed to talk to the supervisor about it. Petitioner noted that it was Friday and sometimes the supervisor was not there. Petitioner noted it read it occurred about 1:00am and Petitioner requested he be called if the supervisor (Mike) was not there when Petitioner left. Petitioner left his phone number and signed and printed his name on it. It was noted some changes, scribbles, marks on the copy and Petitioner stated he did that. Petitioner testified when he finished writing the note he left it on his boss' desk (Mike Little) between 1:00 and 1:30am. Petitioner testified when he left work that day he was advised by Mike Little that he had been terminated. Petitioner testified he left Respondent that day at about 6:30 or 7:00am. Petitioner testified over the next 1-2 hours after his left hand/arm started to get worse and worse and swelling and numbness in the left little and ring fingers.

- Petitioner testified he sought medical care that morning July 12, 2013 at TCA Health; his primary care doctor; he went as a walk in. Petitioner testified that he gave the doctor a history of what occurred and why he was there. Petitioner testified he told the doctor he had been hurt about 1:00am and the doctor examined Petitioner and they asked Petitioner to treat with an orthopedic specialist. Petitioner returned there July 22, 2013 and he was again examined and it was suggested that Petitioner see an orthopedic specialist. Petitioner called and made an appointment with Dr. Blair Rhode at Orland Park Orthopedics, as Petitioner had treated there before when he was recommended an ortho. Petitioner testified that he believed that the first visit with Dr. Rhode was August 12, 2013. Petitioner indicated at that time his hand and arm were still bothering him.

Petitioner testified that at that point, as he had been terminated from Respondent, he was looking for another job. Petitioner testified that he went to work for CBLS Transportation as a mechanic doing the same type of work. Petitioner testified he worked there for about a week. He stated at that time he had the same numbness to the fingers and same swelling in the back of his left elbow. Petitioner testified that while he was working at CBLS he whacked his right hand and had received some medical care at TCA Health on August 10, 2013. He did then see Dr. Rhode August 12, 2013 and gave a history of what happened and the doctor examined Petitioner and recommended some diagnostics and took Petitioner off of work. Petitioner testified since that time in 2013 through present he had returned to Dr. Rhode periodically. Petitioner testified that during that time Dr. Rhode never returned him to work. The doctor prescribed an EMG in mid-September 2013 and Petitioner returned October 16, 2013 and again reported to the doctor the problems and how he was doing. While waiting for authorization for the EMG, the doctor kept him off work. Petitioner stated that he saw the doctor in November and December and again reported his problems. The doctor continued to recommend the nerve test and they were still waiting for the authorization from the carrier. During 2014 Petitioner periodically saw the doctor on a monthly basis. Petitioner saw the doctor January 27, February 24, and March 24, 2014 and the doctor continued Petitioner off work and his recommendation of an EMG at each visit. At some point the carrier did authorize the EMG and that was performed at Neurology Consultants on April 22, 2014. Petitioner testified that he had complied with what the doctors said. Petitioner testified that he saw Dr. Rhode on April 28, 2014 to discuss the test results. At that point Dr. Rhode recommended medications, gave Petitioner a pad and splint and continued Petitioner off work.

- Petitioner went for a §12 examination with Dr. Neal May 12, 2014 at Respondent carrier's request. Petitioner testified that at the examination, he talked to the doctor and answered his questions the best he could and was examined by the doctor. Petitioner stated the discussion with the doctor was 45 minutes to an hour and the exam was not even 10 minutes. The doctor did not treat Petitioner or provide any recommendations for treatment. Petitioner returned to see Dr. Rhode May 19, 2014 and again he reported how he was doing and he testified that the doctor put some needles in his left arm to draw some fluid, and again the doctor kept him off work. Petitioner again returned to Dr. Rhode June 2, 2014 and Petitioner gave additional history of how he was doing and they discussed the report of Dr. Neal, the IME doctor. Dr. Rhode continued to recommend additional care and for Petitioner to be off work. Dr. Rhode then suggested surgery to the left elbow. Petitioner again saw Dr. Rhode June 27, 2014 and they again discussed the problems and the exam with Dr. Neal. Dr. Rhode kept him off work and recommended surgery for which he was awaiting authorization. Petitioner testified that he saw Dr. Rhode on August 1 and 14 and again August 29, 2014 with the same recommendations and off work pending surgical authorization. Petitioner continued with conservative care follow ups October 6, 2014, November 12, 2014, mid-January 2015 and then February 16, 2015 with the same recommendations. Petitioner testified that they were still awaiting

surgical authorization and he has still been authorized off work. Petitioner stated that he was to see Dr. Rhode again April 1 or 2, 2015 (the §19(b) hearing was held March 25, 2015). As to the surgical procedure, Petitioner testified that he did not have the money to pay the doctor and hospital bills. He agreed Dr. Rhode has been recommending the surgery for quite some time and he would like to have it done. Petitioner testified that he has been off work since August 12, 2013 and during that time he has not received any temporary total disability (TTD) benefits; he has received an advance of $5,000.00 from the carrier.

- Petitioner reviewed PX 1, the compilation of the medical bills, and indicated they had not been paid by Respondent carrier. Petitioner testified that prior to July 2013 he had never hurt his left arm or hand and since he had not sustained any other injuries to his left arm or hand. Petitioner agreed he had previously treated with Dr. Rhode in September 2007 for a right knee surgery, July 2008 for treatment to his right shoulder, July 2009 for some low back problems, and in September 2010 regarding his right elbow. He agreed some of that treatment had involved WC related injuries and all those matters had been settled.

- Petitioner testified that currently he still has problems with his left hand with repeated lifting; it irritates the nerve in his elbow into his fingers. He stated that he had pain and swelling behind his left elbow and when the weather changes it really causes him problems, the nerve in his left elbow jumps, throbs. Petitioner testified that driving is a problem his left becomes a problem; he stated that is the same with repetitive lifting. Petitioner stated that he must sleep in a certain position; if he lays on his left side his left arm elbow up to his little and ring fingers gets numb and sometimes wakes him in the middle of the night. Petitioner stated that with his kids, or any types of activities around the house, any vibratory activities like grass cutting or things like that, irritates the nerve. He indicated he can lift a gallon of milk but after lifting a while his grip goes numb. Petitioner testified that he never had those problems before July 2013.

The Commission finds Petitioner's testimony is unrebutted as to accident and a condition of ill-being, which is supported in the records of Dr. Rhode, but as the Arbitrator noted that there are some issues of credibility. Petitioner's testimony of the mechanism of injury is consistent in the medical records. There is some question with the sudden appearance of the 'note' Petitioner left for Mr. Little that was not found in his office (locked when he is not around) until sometime later and also Petitioner was terminated the day of the accident and did not verbally tell Mr. Little of the accident at the time of termination. Also Petitioner testified that only he and Mr. Little were present at time of termination. Although Petitioner was on probation at the time, Mr. Little testified that the shop union representative, Greg Crespo, was also present at the time of termination which would be consistent with a union shop even though Petitioner could get terminated during the probationary period with no union recourse. Mr. Little testified of Petitioner being terminated due to poor attendance and job performance; therefore, it is more than likely that a union representative would have been present. Petitioner's testimony is rebutted

that only he and Mr. Little were present at the time of Petitioner's termination. Also, it seems unlikely that the incident occurred and Petitioner had the relatively severe complaints and symptoms he said he had that Petitioner would not have advised Mr. Little even prior to being told he was being terminated, or even telling Mr. Little he left a note (albeit in a locked office; more to question credibility). The Arbitrator questioned Petitioner's credibility as did Respondent's examiner, Dr. Neal, even though he diagnosed the cubital tunnel condition, though not causally related. Also, several times throughout testimony, before answering a question, Petitioner would say 'if I am not mistaken', which prefaces many answers and again raises credibility issues, as appearing evasive or contradictory as noted by the Arbitrator. The Arbitrator noted Petitioner's demeanor at hearing was 'one of evasion and contradiction', and again his prefacing of answers bears that out. The Commission further notes that the opinions of Dr. Rhode appear to be made on inaccurate assumptions in that he did not know that Petitioner had worked elsewhere since (even for a short time) and had yet another injury. The evidence and testimony in this record finds clear discrepancies and credibility issues with Petitioner. With the totality of the evidence and testimony, the Commission finds that Petitioner met the burden of proving accident that arose in and out of the course of employment and meet the burden of proving some causal relationship, but, not to his current condition of ill-being. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence. The Commission, herein, affirms and adopts the Arbitrator's finding of accident, and further affirms and adopts the Arbitrator's finding as to some causal connection (however limited—not to his current condition of ill-being).

The Commission, with the above finding of accident and some causal connection (not to his current condition of ill-being), finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to denial of further total temporary disability beyond that awarded.

The Commission, with the above finding of accident and some causal connection-(not to his current condition of ill-being), finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to denial of further medical expenses/prospective medical beyond that already awarded.

The Commission finds that as this matter was heard under §19(b) of the Act, the parties did not stipulate to the issue of permanency, therefore, the permanent partial disability award was premature, as Petitioner was not given opportunity to present evidence in that regard. Under the facts and circumstances set forth in this record, the Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein vacates the Arbitrator's finding regarding Permanent partial disability and remands the matter for evidence and the determination of PPD.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $693.33 per week for a period of 3-6/7 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

16IWCC0370

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 sums for medical expenses under §8(a) of the Act; Respondent shall pay the reasonable and necessary charges for medical services provides to Petitioner by TCA Health July 12, 2013, July 22, 2013, and per the fee schedule.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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.

JUN 3 - 2016

DATED:
o-4/14/16
DLG/jsf
045

David Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES, CORTNEY
Employee/Petitioner

Case# **13WC023829**

16IWCC0370

USF HOLLAND INC
Employer/Respondent

On 8/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0230 FITZ & TALLON LLC
PATRICK A TALLON
PO BOX 6040
WOODRIDGE, IL 60517

0766 HENNESSY & ROACH PC
CHRISTOPHER JARCHOW
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Cortney Jones
Employee/Petitioner

v.

USF Holland, Inc.
Employer/Respondent

Case # **13** WC **23829**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **March 25, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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 the date of accident, **7/12/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**4,609.44**; the average weekly wage was $**1,040.00**.

On the date of accident, Petitioner was **33** years of age, ***single*** with ***one*** 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 $**5,000.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**5,000.00**.

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

ORDER

Respondent shall pay reasonable and necessary charges for medical services provide to Petitioner by TCA Health for the dates of July 12 and July 22, 2013, adjusted in accord with the fee schedule as provided by § 8(a) and § 8.2 of the Act.

Respondent shall pay total temporary disability benefits from **July 12, 2013** through **August 8, 2013, 3 & 6/7** weeks, at a rate of **$693.33**/week.

Respondent shall Petitioner permanent partial disability benefits of **$624.00**/week for **5.06** weeks, due to the injury causing 2% loss of use of an arm.

Respondent shall be given credit for **$5,000.00** of previously paid 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

August 19, 2015
Date

ICArbDec19(b)

AUG 20 2015

Courtney Jones v. USF Holland, Inc.
13 WC 23829

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth on March 25, 2015. Disputed issues were: ***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:*** What temporary benefits are in dispute? TTD?; ***L:*** What is the nature and extent of the injury?

Petitioner and Mr. Mike Little testified at hearing. Petitioner offered documents in evidence. Respondent objected to Petitioner's Exhibit #1 and the Arbitrator reserved ruling on its admissibility. Respondent offered documents in evidence also. Petitioner's objection to Respondent's Exhibit #1 was sustained. All other offered exhibits were admitted without objection.

FINDINGS OF FACT

Petitioner was employed as a truck mechanic by Respondent since May 2013. He was hired as a full time union mechanic at an hourly rate of $26.00 per hour. Petitioner worked out of Respondent's shop in McCook, Illinois. Initially, he worked from 6:00 a.m. until 2:30 p.m. His work shift changed to the midnight shift, from midnight to 8:30 a.m.

Petitioner testified on July 12, 2013 his daily work activities of a truck mechanic included working on diesel trucks with various hand tools, air tools, hammers, chisels, and impact guns. His job would require him to lift and carry parts and materials weighing up to approximately 100 pounds. In order to perform his job Petitioner needed to use both hands and both arms. Petitioner is right-handed.

Petitioner testified that at about 1:00 a.m. on July 12, 2013 he was installing a brake chamber. While tightening a lock nut, his wrench slipped off and his left elbow struck the tractor. He had immediate pain and numbness in the small and ring fingers. He also had swelling in his left elbow. On cross-examination he testified his immediate pain was 10/10. Despite worsening pain on direct examination Petitioner testified he continued to work until 6:00 a.m. or 6:30 a.m. When the actual event occurred, there were no other coworkers or supervisors who witnessed the event.

Petitioner left a note for his supervisor to inform him of the accident and his injury (PX #5), since his supervisor was not present when the accident happened. Petitioner also left his telephone number for his supervisor. Petitioner placed that note on the desk of his boss, Mike Little.

Petitioner testified that he was called into Mr. Little's office between 6:00 and 6:30 a.m. at which time he reported his injury. No one else was present during that conversation. Petitioner testified that Mr. Little's only response was that Petitioner had not satisfactorily completed his probationary period and that Petitioner was being terminated. Petitioner testified that even though he informed Mr. Little of the injury, Mr. Little made no comments regarding the injury nor did he ask Petitioner to complete an accident report.

Petitioner sought medical care the day of the injury at TCA Health (TCA), his primary care physician. (PX #2) Petitioner had treated at TCA for many years for colds, flu, and episodes of vertigo. He had also been treated for work-related injuries that did not involve the left hand or arm. The TCA records from July 12, 2013 note Petitioner's complaint of left elbow pain at 8/10, as well as numbness and tingling in his fourth and fifth fingers. There was no swelling or bruising yet. The doctor's initial diagnosis was elbow injury, deteriorated ulnar nerve contusion "effecting" (*sic*) the fourth and fifth digits. There was no note regarding Petitioner's capability to return to work.

Petitioner returned to TCA on July 22 for a recheck. He reported that his pain varied from 8/10 to 0/10. Petitioner noted that there had been swelling but the doctor documented there was no joint enlargement or tenderness. The treating physician assessed an ulnar nerve injury and recommended an orthopedic consultation.

Petitioner testified that he began working for a new employer, CBSL Transportation (CBSL), as a truck mechanic in August, 2013, about 3 weeks after the July 12, 2013 accident. Petitioner testified that his job duties were similar to those he had with Respondent. Petitioner testified he used the same type of tools as he did for Respondent. Petitioner testified he was required to use both hands in his job with CBSL.

Petitioner testified that he worked for CBSL for one week. Petitioner sustained a hand injury while working for CBSL on August 9, 2013. He was terminated from his employment with CBSL on August 9. Petitioner testified that he also filed a subsequent Workers' Compensation claim against CBSL alleging an injury to his right hand as a result of his August 9 accident at work, the same day he was terminated from CBSL. Petitioner testified that claim was settled for a "nominal amount."

Petitioner was seen at TCA again on August 10, 2013 for a right hand injury. There were no notes of comaplints about his left elbow injury from July.

Petitioner elected to treat with Dr. Blair Rhode of Orland Park Orthopedics (PX #3), who had treated him for 8 prior workers' compensation claims. None of the prior injuries or care was to the same part of the body claimed from the July 12, 2013 accident: the left hand, left arm, and left elbow. Petitioner did have right knee surgery in September 2007, right shoulder surgery in July 2008, low back treatment in July 2009, and treatment to the right elbow in September 2010. These prior work related injuries were all settled and approved by the Illinois Workers' Compensation Commission.

On August 12, 2013 Petitioner presented at Orland Park Orthopedics (Orland) and again provided a history of the work injury of July 12. There was no gross edema or evidence of acute injury. On exam Petitioner had full range of motion in his left elbow but pain at the medial and lateral epicondyle. Further examination revealed positive tennis elbow test, positive Tinel, positive cubital tunnel sign producing paresthesia over ulnar distribution, and negative Spurling's sign. Dr. Rhode diagnosed cubital tunnel syndrome and lateral epicondylitis. Dr. Rhode noted that Petitioner sustained a traumatic injury to the "right left" elbow secondary to a direct impact on July 12, 2013. Dr. Rhode prescribed Norco, Mobic, ands Prilosec. He also recommended an EMG study.

In addition, Dr. Rhode recommended that Petitioner be off work. Petitioner has not returned to work through the date of hearing, March 25, 2015, a total of 84 & 1/7 weeks. No weekly TTD benefits have been paid to the Petitioner for his lost time. Petitioner did receive an advance payment of $5,000.00 prior to the hearing.

Petitioner returned for follow up at Orland on November 11, 2013 continuing with the same clinical presentation. Dr. Rhode's diagnoses and recommendations were the same also. A visit at Orland on December 16, 2013 was the same. Nothing had changed on January 27, 2014 or February 24, 2014.

On March 24, 2014, Petitioner returned to Orland and was advised that the EMG had been approved. The approved diagnostic was scheduled by the staff at Orland and the doctor continued with his recommendation that Petitioner stay off work.

The EMG/NCV of the left arm was conducted at Neurology Consultants (PX #4) on April 22, 2014. The study was normal but for a finding of a mild ulnar neuropathy at the left elbow.

On April 28, 2014, Petitioner returned to Orland and discussed the diagnostic study findings with his P.A. Mark Bordick. Petitioner was instructed in stretching exercises and advised to use a night splint. P.A. Bordick noted for the chart the ODG indications for surgery, provided medications and an elbow pad for night splinting. Petitioner was to remain off work per instructions.

On May 19, 2014 Dr. Rhode injected Petitioner's left elbow with a corticosteroid. The medical indication for the injection was not documented. Petitioner returned to Dr. Rhode on June 2, 2014 with continuing complaints. Petitioner reported temporary relief from the injection. Petitioner was status post IME with Dr. Neal but the report of the IME had not been released to Dr. Rhode.

Petitioner was examined by orthopedic surgeon Dr. Bryan Neal pursuant to § 12 of the Act on May 12, 2014. Dr. Neal testified at his evidence deposition on January 30, 2015. In testimony he refreshed his recollection by referring to his report to Respondent's counsel dated May 27, 2014. Dr. Neal reviewed various records in addition to the clinical examination to come to his opinions.

Dr. Neal reviewed a copy of Petitioner's note to Mike Little dated 7/12/13 (PX #5), clinical and other records of Dr. Rhode, and the EMG/NCV notes of Dr. Scott

Lipson. Petitioner gave a history of 2 prior IMEs relating to other injuries. Petitioner reported that he last worked for USF Holland. Petitioner did not report that he was reemployed with CBSL Transportation within a few weeks of the July 12, 2013 reported injury or that he had been injured on that latter job. Petitioner reported that he had 3 prior workers' compensation claims against UPS. Dr. Rhode had performed surgery for some of those prior injuries.

Petitioner stated that he did not know why he had been referred to Dr. Neal for evaluation. Petitioner reported that he had been diagnosed with cubital tunnel syndrome and lateral epicondylitis. Petitioner described his accident as he did on his testimony at hearing. On exam Petitioner complained of left elbow pain on the "outside" and numbness from the medial aspect of the left elbow down the forearm into the ring and small fingers. Dr. Neal conducted a thorough clinical examination.

Dr. Neal found that Petitioner's presentation was consistent with cubital tunnel syndrome. He did not find conclusive evidence of lateral epicondylitis. Dr. Neal opined that the mechanism of injury as described by Petitioner would not cause epicondylitis. He found that Dr. Rhode did not document clinical findings that would support a diagnosis of epicondylitis.

Dr. Neal acknowledged that the described mechanism was competent to cause traumatic cubital tunnel syndrome. However, Dr. Neal had questions about Petitioner's credibility and reliability as a historian. Dr. Neal would have liked to see Petitioner's medical records from Dr. Neal to get a better picture of Petitioner's history. In the end, Dr. Neal opined that he could find a causal relationship between either the possible lateral epicondylitis or the cubital tunnel condition and the reported accident on July 12, 2013.

Petitioner returned to Dr. Rhode on June 27, 2014. Dr. Rhode had reviewed the IMR report of Dr. Neal. He noted, "I agree with Dr. Neal that there is no causation for lateral epicondylitis. I have never diagnosed the patient with epicondylitis." He noted that Dr. Neal did not believe Petitioner's description of the mechanism of injury but that if the description was accurate causal connection is possible. Dr. Rhode believed Petitioner's description of the injury was accurate. Dr. Rhode signed another off work status note. His assessment of Petitioner's condition included elbow pain, cubital tunnel syndrome, and lateral epicondylitis.

On August 1, 2014, Petitioner returned to Dr. Rhode with an unchanged presentation. He continued to wait for cubital tunnel treatment authorization and noted that Petitioner should not work. Dr. Rhode dropped epicondylitis from his assessment list on this visit.

On August 29, 2014, Petitioner again returned to Dr. Rhode with continued complaints and an assessment of elbow pain and cubital tunnel syndrome. Nothing else had changed.

On September 14, 2014 Dr. Rhode wrote a narrative summary of Petitioner's case to that point. The narrative was of the nature of a report made for the purposes of

litigation rather than for therapeutic care. Dr. Rhode reiterated his diagnosis of left cubital syndrome which was caused by the reported work accident on July 12, 2013. He was recommending operative intervention in the form of release surgery. Dr. Rhode's review of Dr. Neal's IME report led Dr. Rhode to reconsider his prior diagnosis of lateral epicondylitis. In his September 14 narrative report Dr. Rhode abandoned his diagnosis of epicondylitis and its relation to the work accident.

Dr. Rhode went on to discuss Dr. Neal's expressed skepticism of Petitioner's credibility. diagnostic revealed cubital tunnel syndrome. Dr. Rhode accepted Petitioner's description of the mechanism of injury and therefore stood by his previous opinion that the cubital tunnel syndrome was causally related to the accident. He continued in his recommendation of surgery.

On October 6, November 12, and December 17, 2014, January 19 and February 16, 2105 Petitioner repeatedly returns for follow-up at Orland Park Orthopedics. His clinical presentation and the doctor's diagnoses and recommendations remained the same.

Dr. Rhode gave his evidence deposition on January 12, 2015. He too testified from recollection from his clinical records. Dr. Rhode described Petitioner's clinical course under his care. He reiterated his diagnosis of left cubital tunnel syndrome and that it was caused by the reported accident on July 12, 2013. He testified that the lateral epicondylitis was not work related. He explained the recurrent entries in his chart notes were from a report template that repeated previous chart entries. He continued in his opinion that Petitioner, because of his injuries, was in capable of working as a truck mechanic. On cross-examination he conceded that he might change that opinion if he knew that Petitioner had returned to work after the July 12, 2013 accident he reported.

Petitioner identified Petitioner's Exhibit 1 (PX #1), a compilation of medical bills for care rendered by his attending physicians associated with the work injury of July 2013. In argument over admissibility Petitioner's counsel stated that the bills comprising PX #1 had been gleaned from the records of the healthcare providers' subpoenaed records.

At the present time Petitioner has complaints including but not limited to difficulty lifting which irritates the nerve in his elbow and fingers; numbness in the ring and small fingers; swelling behind the left elbow; weather changes cause a throbbing sensation in his elbow; driving with his left hand causes difficulty; at night he is awakened when he makes certain movements or with the positioning of his hand and arm which causes significant numbness in the ring and small finger; activities around the house using vibrating tools such as a lawnmower irritate the nerve in his arm; he can comfortably only lift a gallon of milk; grip is weakened and there is numbness in the left hand. Petitioner did not have these symptoms or complaints prior to the work injury of July 2013.

Petitioner was questioned about the histories given his treating physicians and indicated they were true and accurate to the best of his recollection.

Respondent called Michael Little, Petitioner's supervisor at work, as a witness. Mr. Little testified at length regarding Pettioner's notice of injury, an issue not in dispute.

Mr. Little testified that all employees are advised at new employee orientation to report injuries of any magnitude. He confirmed Mr. Jones was a regular full time employee of Respondent in July of 2013 and that he was working within a 60 day probationary period.

Mr. Little recalled a conversation with Petitioner about 6:30 in the morning on July 12, 2013 which included Petitioner, Mr. Little and union steward Greg Crespo. The meeting was to inform Mr. Jones he was being terminated because of poor performance and attendance. Mr. Little denied that Petitioner had ever personally informed him of the injury that he had on July 12, 2013 at work. Mr. Little recalled another conversation with Petitioner on or about July 16, 2013 at which time Mr. Jones wanted to set up a time to pick up his toolbox and no other issues were discussed in that conversation.

Mr. Little testified that on or about July 22, 2014 he did, in fact, find a note from Petitioner on his desk (PX #5). He testified that he found the note underneath his desk calendar. He looks under the calendar every Monday to do payroll and that is when the found the note. He admitted that it was signed by Petitioner.

Mr. Little testified that his office was locked and that he checked under his calendar daily between July 12 and July 22, 2013 but he did not find this note until July 22, 2013. Respondent offered Respondent Exhibit #1 and asked Mr. Little to identify it. Mr. Little indicated it was a photocopy of the note he found under his desk calendar. He testified that it was a true and accurate copy of that note.

On cross-examination, Mr. Little testified that probationary employees and union members are not treated differently in terms of policy and procedure. The provisions of the union contract apply to both equally. Mr. Little testified that termination policies would not be applicable to probationary employees, only regular union employees.

CONCLUSIONS OF LAW

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

The Arbitrator observed the testimony of all witnesses and reviewed all other evidence. Based on all of the evidence the Arbitrator finds that Petitioner is not a credible witness. His demeanor at hearing was one of evasion and contradiction.

Petitioner testified that there was no one else at his conversation with his supervisor Mike Little on July 12, 2013. This conversation was for the purpose of

terminating Petitioner during the probationary period of his employment with Respondent. Mike Little testified that the union steward Greg Crespo was also present at that conversation. It is unlikely that a union steward would not be present during a termination conference in a union shop. It is also possible that an employee who was just fired might not mention bumping his elbow earlier in the work shift. The Arbitrator finds that Mike Little is more credible in his account of the July 12 conversation.

In addition, Petitioner went to work as a truck mechanic within weeks of his reported injury at Respondent's shop. This is not consistent with his testimony regarding the nature and extent of his injuries or the degree of pain complained of. In fact, Petitioner claimed he was injured in that new job, a fact he did not disclose to his treating physician, Dr. Rhode. In fact, Petitioner told Dr. Rhode that he had not worked since his July 12 accident.

When Petitioner sought care at TCA Health for his right hand injury with CBSL there was not mention in the record of the left elbow injury or complaints of left elbow or arm pain or numbness. Petitioner complained of disabling injuries as a result of a July 12, 2013 accident at work. He did not inform Dr. Rhode that he had been working as a mechanic after July 12.

Despite the foregoing, the Arbitrator finds that an accident did occur that arose out of and in the course of Petitioner's employment by Respondent. Despite his problems with credibility Petitioner testified that he struck his left elbow while working on one of Respondent's trucks. He sought medical care on the same day and presented with signs and symptoms of a contusion and possible ulnar nerve contusion.

Therefore, the Arbitrator concludes that Petitioner sustained an accident arising out of and in the course of his employment with Respondent on July 12, 2013.

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

The Arbitrator finds that Petitioner failed to prove that his current claimed state of ill-being is causally related to the accident.

The Arbitrator previously found Petitioner was not a credible witness. He withheld information from his treating physician, Dr. Rhode, about his new job with CBSL Transportation. This belies the claims Petitioner made about the extent of his injuries and his disability from those injuries. Likewise, Petitioner did not tell Dr. Rhode about his new job as a mechanic and his subsequent work accident. Petitioner apparently did not complain about his claimed accident injuries when he sought care at TCA Health for the later right hand injury.

Dr. Rhode conceded that he might have changed his opinions regarding Petitioner's ability to work had he known Petitioner returned to work as a mechanic after the July 12 accident. The Arbitrator also takes note that Dr. Rhode's deposition testimony contradicted his own chart notes. In addition, Dr. Rhode did not document the medical indication for the corticosteroid inject he administered. In light of these

significant discrepancies the Arbitrator cannot find Dr. Rhode's opinions persuasive. Dr. Neal, who conducted a thorough review and examination, was more persuasive in his opinions and, therefore, the Arbitrator accepts Dr. Neal's opinions that proof of causation was lacking.

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

Taking into account the foregoing findings the Arbitrator finds that Petitioner proved that the only reasonable and necessary medical he received for his claimed work-related injuries was at TCA Health on July 12 and July 22, 2013. Petitioner had started working at CBSL Transportation in August 2013, indicating he was at MMI. The actual start day is uncertain. What is certain is that Petitioner claimed a new work injury on August 9, 2013.

Therefore, the Arbitrator finds that Petitioner had achieved MMI by August 8, 2013 and that any medical care for injuries claimed as a result of an accident on July 12, 2013 after August 8 were not reasonably necessary to alieve or cure any injuries sustained in the course of employment by Respondent.

Respondent shall pay charges for medical services provided by TCA Health on July 12 and July 22, 2013, adjusted in accord with the fee schedule.

K: What temporary benefits are in dispute? **TTD**

In consideration of previous findings the Arbitrator concludes that petitioner is entitled to TTD benefits from July 12, 2013 through August 8, 2013, a total of 3 & 6/7 weeks of temporary total disability, at a rate of $693.33 per week.

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

The Arbitrator evaluated Pettioner's claim for PPD in accord with § 8.1b of the Act.

(i) No level of impairment according to application of AMA "Guidelines to the Evaluation of Permanent Impairment" was submitted in evidence. The Arbitrator cannot give any weight to this factor.

(ii) Petitioner was a truck mechanic at the time of his claimed injury. He had a statistical worklife expectancy of 26 years. The Arbitrator gives moderate weight to this factor.

(iii) Petitioner was 33 years old at the time of the accident. Petitioner had a statistical life expectancy of 44 years. The Arbitrator gives this factor

moderate weight.

(iv) Petitioner testified that due to his injuries on July 12, 2013 he has been to work as a truck mechanic. There was proof that Petitioner began working as a mechanic within weeks of his claimed injury. The Arbitrator gives great weight to this factor.

(v) The Arbitrator reviewed Petitioner's medical records as well as the deposition of his treating physician and Respondent's expert's deposition. The Arbitrator gives great weight to this factor.

In light of all factors the Arbitrator finds that Petitioner sustained a 2% loss of use of his left arm as a result of injuries suffered in his work-related accident on July 12, 2013.

August 19, 2015

Steven J. Fruth, Arbitrator

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

Cynthia Cantwell,

Petitioner,

vs. NO: 12 WC 27153

State of Illinois/University of Illinois-Springfield,

Respondent.

16IWCC0371

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 compliance with vocational rehabilitation and nature and extent, 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.

In *ABBC-E v. Industrial Commission*, 316 Ill. App. 3d 745, 750 (2000), the court explained that a claimant can demonstrate permanent and total disability in three ways:

> "[B]y a preponderance of the medical evidence, by showing a diligent but unsuccessful job search, or by demonstrating that because of their age, training, education, experience, and condition, no jobs are available to a person in their circumstances."

Regarding the first prong, the medical evidence, the Commission notes that the record clearly establishes that none of Petitioner's treating doctors or the Respondent's Section 12 examiner opined that Petitioner is totally disabled. Dr. Idusuyi, Petitioner's treating physician, opined that Petitioner can work at the medium demand level, per the Functional Capacity Examination (hereinafter "FCE"). (PX4) The Commission notes that the FCE determined that Petitioner functioned at a medium demand level (21-50 lbs) with material handling tasks of waist to floor lifting, waist to crown lifting and front carrying, and ambulation based activities (carrying, stair ambulation, ladder climbing) are limited to occasional basis. (PX6) Dr. Idusuyi placed the following permanent restrictions on Petitioner: full time work (8 hours a day/5 days a week), no lifting/carrying greater than 40 lbs, pushing/pulling up to 70 lbs, carry items on a frequent basis, limited stair climbing, ladder climbing not recommended, limited crouching or squatting for any prolonged amount of time, walking limited to 50% or less of her 8 hour shift, standing limited to 75% or less of her 8 hour shift, and capable of working on even or uneven surfaces. (PX4) Therefore, the Commission finds that the medical evidence clearly establishes that Petitioner is not permanently and totally disabled.

Regarding the second prong of *ABBC-E*'s analysis, Petitioner had to show a diligent but unsuccessful job search. As noted by the court in *ABBC-E*, "[i]t is well settled that the question of whether a claimant is permanently and totally disabled is a question of fact for the Commission." *ABBC-E*, 316 Ill. App. 3d at 750. Similarly, it is within the province of the Commission to determine the sufficiency of the Petitioner's vocational rehabilitation efforts.

Petitioner underwent a vocational rehabilitation evaluation by James Ragains, a vocational rehabilitation counselor, at her attorney's request. (PX9) Mr. Ragains opined that Petitioner's self-directed job search had been one of the "most diligent and well documented and comprehensive job searches I have ever witnessed." (PX9) After reviewing Petitioner's job search records, the Commission finds that while Petitioner's job search was wide in scope, the effectiveness of her method, via "cold" contacts, not to mention her application for jobs for which she could not perform due to her restrictions, is of questionable value.

The Commission notes that among the jobs Petitioner applied for were hostess, waitress, store/office manager, collections manager, account manager, property manager, assistant manager, cashier, loan consultant, financial service representative, administrative/office assistant, receptionist, event planner/event coordinator, barista, jewelry/cosmetic/baby registry consultant, beauty advisor, data collection associate, cafeteria manager, food administrator, food server, cook/prep cook, bartender, shift supervisor, concierge, janitorial supervisor, bakery/deli worker, grocery checker, public health inspector, photographer, catering staff/catering manager, call center manager, rehabilitation support staff, driver/shuttle, and medical records scanner. (PX8) The Commission notes that most of those positions either require standing more than 75% of the day or education and/or training that Petitioner does not have. Petitioner's decision to apply for many of these jobs was unreasonable, and doomed her to failure, since she clearly did not qualify for them and/or lacked the physical ability to perform them. Though she may have been well intentioned, Petitioner's actions did not constitute a diligent job search.

The Commission also notes that the Respondent hired Ms. Amanda Ortman, a Vocational Counselor, to assist the Petitioner in her job search activities. Ms. Ortman indicated that while the Petitioner seemed to be quite active in her efforts, there were some discrepancies in Petitioner's job search.

Ms. Ortman set up a job search e-mail account for the Petitioner. By this account, Petitioner was to access all job leads given by Ms. Ortman and apply for any job within her restrictions. Ms. Ortman testified that there were 100 job lead e-mails in the Petitioner's account that were never opened. Additionally, Ms. Ortman alleged that the Petitioner gave inappropriate information to potential employers by applications and during interviews, thus sabotaging the interviews.

Ms. Ortman noted that Petitioner's counsel sent her a letter regarding his "concern about a TRIUNE HG [Ms. Ortman's employer] developed job lead at UIS [University of Illinois-Springfield] for a Food Service position, however; [Petitioner] has applied to UIS on her own behalf for this same position. It is this writer's opinion that if [Petitioner] feels the position is suitable enough for her to apply on her own behalf; it is suitable for TRUINE HG to provide similar leads." (RX1)

The Commission finds the claim of Petitioner's attorney indicative of the chasm that exists between Ms. Ortman and the Petitioner. Ms. Ortman suggested that the Petitioner apply for jobs that were theoretically beyond Petitioner's restrictions and in the same breath suggested

that Petitioner was sabotaging the job search process when Petitioner applied for the same or similar jobs, in her self-directed search. The Commission finds that the self-directed search, though well intentioned, did not constitute a diligent effort. Additionally, the Commission finds that the Petitioner's lack of diligence was contributed to in whole or in part by Ms. Ortman's flawed assistance.

Finally, regarding the third prong in *ABBC-E*, the Commission finds that Petitioner failed to establish that because of her age, training, education, experience and condition, no jobs are available to her. The Commission notes that at the time of her accident she was 48 years old, had earned an Applied Associate's Degree in Food Service Management in 1988 and has considerable experience in the food services industry. Furthermore, Petitioner has basic computer skills after undergoing a computer training course on Office Suites which was provided by her long-term disability benefits provider. (T.40) The Commission further notes that Petitioner does a three to four hour radio show on Monday mornings, for which she prepares by downloading music from CD's and converting them into computer files, to play during her show. (T.53-54) While Petitioner's radio job does not pay, the Commission finds that it does indicate a basic understanding and use of computers by Petitioner.

In *Westin v. Industrial Commission*, 372 Ill. App. 3d 527, 545 (2007), the court noted that "most recent cases making an odd lot determination on the basis 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." Mr. Ragains determined that Petitioner "clearly cannot return to the work she performed at the date of injury" and while she could arguably "function in a food service management capacity," that would be unlikely due to her "limitations for standing and walking during the course of an 8-hour day." (PX9) However, Mr. Ragains opined that Petitioner could be "vocationally rehabilitated and returned to gainful employment if she were afforded an opportunity to undergo further skills training at Lincoln Land College in Springfield, IL for work that would be more Sedentary." (T.78) Mr. Ragains further explained that an "Office Professional Associate in Applied Science Degree program offered at Lincoln Land College which would prepare [Petitioner] for secretarial and administrative assistant work" would provide the adequate retraining needed to make Petitioner gainfully employable. Considering Mr. Ragains testimony that the unemployment rate in Central Illinois and Springfield is between six and 7 percent and that the labor market was becoming more constrained and competitive (T.78), the Commission finds such a recommendation is, in light of the evidence submitted and Ms. Ortman's failure to provide a vocational rehabilitation evaluation of Petitioner, reasonable and persuasive.

Therefore, based on the totality of the evidence, the Commission finds that Petitioner has failed to establish that she falls under the odd lot theory for permanent total disability benefits as laid out in *ABBC-E*. The Commission hereby reverses and vacates the Arbitrator's finding and award of permanent and total disability and finds that Petitioner is entitled to vocational rehabilitation in the form of retraining for an Office Professional Associate in Applied Science Degree program offered at Lincoln Land College as recommended by Mr. Ragains. The Commission also awards maintenance benefits during Petitioner's retraining pursuant to Section 8(a) of the Act. The Office Professional Associate in Applied Science Degree program requires the completion of 61 credits and should be completed within two years/four semesters.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. Furthermore, we have considered all

of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on October 20, 2015 is modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $407.28 per week for a period of 160-4/7 weeks, from July 24, 2012 through August 21, 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 authorize and pay for vocational rehabilitation benefits in the form of retraining for an Office Professional Associate Degree in the Applied Science Degree program offered at Lincoln Land College as recommended by vocational rehabilitation counselor James Ragains.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay maintenance benefits to Petitioner during vocational rehabilitation.

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

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

DATED: JUN 6 - 2016
MJB/ell
o-05/16/16
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CANTWELL, CYNTHIA
Employee/Petitioner

Case# **12WC027153**

16IWCC0371

UNIVERSITY OF ILLINOIS-SPRINGFIELD
Employer/Respondent

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

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

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

2934 BOSHARDY LAW OFFICE PC
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100 TRADE CENTER DR
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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

OCT 20 2015

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

16IWCC0371

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Cynthia Cantwell
Employee/Petitioner

v.

University of Illinois - Springfield
Employer/Respondent

Case # 12 WC 27153

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 Springfield, on August 21, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0371

FINDINGS

On February 17, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $31,767.84; the average weekly wage was $610.92.

On the date of accident, Petitioner was 48 years of age, single 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 $61,773.37 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $61,773.37.

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 $407.28 per week for 160 4/7 weeks commencing July 24, 2012, through August 21, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent total disability benefits of $483.36 commencing August 22, 2015, for life as provided in Section 8(f) of the Act. Commencing on the second July 15th after entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

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

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

William R. Gallagher, Arbitrator — October 13, 2015
Date

ICArbDec p. 2

OCT 20 2015

Evidentiary Rulings

At trial, Respondent's counsel objected to those portions of Petitioner's Exhibits 8 and 9 that contained statements made by third parties who did not testify at trial regarding Petitioner's inability to meet the physical demands of various jobs (TR; pp 9-10).

Petitioner's Exhibit 8 is her job search documentation and is rather voluminous. The exhibit consists primarily of a log of prospective employers contacted by Petitioner, the job sought by her, whether an application was tendered, etc. To the extent that Petitioner's Exhibit 8 contains inadmissible hearsay, the objection is sustained and those portions of Petitioner's Exhibit 8 are stricken.

Petitioner's Exhibit 9 is reports of James Ragains, the vocational expert retained by Petitioner's counsel. As is noted herein, Ragains testified when this case was tried. The Arbitrator has reviewed Petitioner's Exhibit 9 and the only portion of it that Respondent's counsel's objection seems to be directed to are statements made by Crystal Rutherford, the Manager of Romantix Boutique, where Petitioner had applied for a job (Ragains supplemental report dated August 11, 2015; p 3). Respondent's hearsay objection is sustained as to that portion of Petitioner's Exhibit 9 and it is stricken.

Petitioner's counsel objected to that portion of Respondent's Exhibit 1 which contained statements of a prospective employer who did not testify at trial (TR; p 10). The Arbitrator has reviewed Respondent's Exhibit 1 and notes that the objectionable statements were made by someone named "Ali." (Vocational progress report dated July 7, 2015; p 5). Petitioner's hearsay objection is sustained as to that portion of Respondent's Exhibit 1 and it is stricken.

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on February 17, 2012. According to the Application, Petitioner was hit by a utility cart and sustained an injury to her right lower extremity. An Amended Application was also filed, but the only difference between it and the original Application that was filed was the average weekly wage that was alleged (Petitioner's Exhibit 1).

At trial, the parties stipulated that Petitioner was temporarily totally disabled from July 24, 2012, through August 21, 2015 (the date of trial), a period of 160 4/7 weeks. The primary disputed issue in this case was the nature and extent of disability. Petitioner alleged that she was an odd-lot permanent and total disability. Respondent's position was that Petitioner was not permanently and totally disabled and further, that Petitioner was not cooperative with their vocational expert (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a Building Service Worker I. This was a full-time position and Petitioner worked 37.5 hours per week. In addition to this job, Petitioner also worked part-time as a waitress/hostess at Fritz's Wagon Wheel.

Petitioner testified that on February 17, 2012, she was pushing a utility cart and one of its wheels turned striking her right foot/ankle. At that time, Petitioner experienced a sharp pain in her right foot/ankle but continued to work even though the symptoms gradually increased.

Petitioner initially sought medical treatment on February 28, 2012, at Koke Mill Medical Associates were she was seen by Melanie Reynolds, a Nurse Practitioner. Reynolds examined Petitioner and opined that Petitioner had sustained a foot/ankle injury. She recommended Petitioner wear an Ace wrap and stay off the foot as much as possible (Petitioner's Exhibit 14).

Petitioner continued to work but her right foot/ankle symptoms worsened. Petitioner was again seen by NP Reynolds on May 14, 2012. Reynolds opined that Petitioner had sustained a foot injury and referred her to Dr. Robert Parker, a podiatrist.

Dr. Parker evaluated Petitioner on May 15, 2012, and opined that she had possible tibial tendinitis. He ordered an MRI scan which was performed on June 20, 2012. The MRI revealed a partial tear of the posterior tibialis tendon and tenosynovitis of the flexor tendon group. On July 24, 2012, Dr. Parker saw Petitioner and reviewed the MRI results with her. He noted that Petitioner's condition had not improved with conservative treatment and authorized her to be off work. He also referred Petitioner to Dr. Osaretin Idusuyi, an orthopedic surgeon (Petitioner's Exhibit 3).

Dr. Idusuyi initially saw Petitioner on July 28, 2012. At that time, Petitioner informed Dr. Idusuyi of the accident and that she continued to have significant right foot/ankle pain. Dr. Idusuyi subsequently diagnosed Petitioner with tarsal tunnel syndrome and tenosynovitis of the flexor hallucis longus tendon. Dr. Idusuyi recommended that Petitioner undergo surgery consisting of a tarsal tunnel release and tenosynovectomy (Petitioner's Exhibit 4).

Dr. Idusuyi performed surgery on January 10, 2013, and the procedure consisted of a tarsal tunnel release, synovectomy of the flexor hallucis longus and tenosynovitis debridement of the tibial tendon (Petitioner's Exhibit 5). Following the surgery, Petitioner continued to be treated by Dr. Idusuyi. When seen by him on March 6, 2013, he noted that she had developed some protuberance from the deep stitches along the medial aspect of the foot. At that time, Dr. Idusuyi performed a debridement and removal of those internal stitches (Petitioner's Exhibit 4).

Dr. Idusuyi ordered physical therapy and work hardening which Petitioner received from January 31, through July 1, 2013 (Petitioner's Exhibit 10). When Dr. Idusuyi saw Petitioner on July 1, 2013, she informed him that her symptoms were worse after the work hardening. Dr. Idusuyi discontinued work hardening and ordered an EMG. The EMG was performed on July 26, 2013, and it revealed slight improvement but a clear ongoing neurological deficit related to right tibial neuropathy and tarsal tunnel syndrome (Petitioner's Exhibit 4). Subsequent to the EMG, Dr. Idusuyi saw Petitioner on July 29, 2013, and he recommended that she undergo a functional capacity evaluation (FCE) (Petitioner's Exhibit 4).

The FCE was performed on August 13 and 14, 2013. At that time, Petitioner advised the examiner that her job for Respondent required prolonged standing/walking, lifting over 50 pounds, pushing/pulling, bending, twisting, turning, moving furniture, climbing stairs/ladders

and operating various machines such as wet vacs and carpet extractors. The FCE report stated that Petitioner gave maximal efforts and that Petitioner could function in the "medium" demand level, meaning she could lift 21 pounds frequently and up to 50 pounds occasionally. Ambulation activities such as walking, ladder/stair climbing, etc. were limited to being performed on an "occasional" basis (Petitioner's Exhibit 6).

Dr. Idusuyi saw Petitioner subsequent to the FCE and, on October 16, 2013, he opined that Petitioner was at MMI and that the work restrictions stated in the FCE were permanent. Dr. Idusuyi again saw Petitioner on December 17, 2013, and opined again that Petitioner was at MMI. In regard to Petitioner's work restrictions, Dr. Idusuyi gave a specific list of the restrictions, specifically, no lifting/carrying greater than 40 pounds; able to push/pull up to 70 pounds; able to carry on a frequent basis; limited stair climbing; ladder climbing not recommended; limited crouching/squatting for any prolonged amount of time; walking limited to 50% or less of an eight hour shift; standing limited to 75% or less of an eight hour shift; capable of working on even or uneven surfaces; and, that Petitioner could work eight hours a day, five days a week (Petitioner's Exhibit 4).

At trial, Petitioner testified regarding her permanent work restrictions. Further, she stated that she wears a "foot boot" that was prescribed by Dr. Idusuyi virtually all of the time including when she sleeps. She confirmed that Respondent did not offer her a job that conformed to her work restrictions.

In October, 2013, Petitioner began a self-directed job search. The records of Petitioner's job search were received into evidence at trial and they were extensive (Petitioner's Exhibit 8). Further, Petitioner testified that she had several job interviews but received no job offers.

At the request of Petitioner's counsel, Petitioner was evaluated by James Ragains, a vocational consultant, on July 29, 2014, and he had further discussions with her by telephone on August 26, 2014. As part of his vocational evaluation of Petitioner, Ragains reviewed Petitioner's education and work history, medical records, FCE and Petitioner's permanent work restrictions. Ragains' initial report was dated September 12, 2014 (Petitioner's Exhibit 9).

In his report, Ragains noted that he performed a transferability of skills analysis using the Occupational Access System (OASYS). In considering Petitioner's past work experience, Ragains only considered the preceding 15 years because skills acquired before 15 years ago may no longer be viable and lose significance over time. Ragains noted Petitioner's work restrictions, the walking restrictions, in particular, neutralized her transferable skills for employment in food services such as serving/preparing food or hostessing. He further opined that Petitioner could not return to work to the job that she had at the time of the accident (Petitioner's Exhibit 9).

Ragains reviewed the documentation regarding Petitioner's self-directed job search. In his report, Ragains stated "I must say that Ms. Cantwell has been and continues to be engaged in perhaps the most diligent and well documented and comprehensive job searches I have ever witnessed dating to October 24, 2013. I have reviewed close to probably two reams of paper consisting of her well documented job search activity." (Petitioner's Exhibit 9).

Ragains concluded that Petitioner was not employable given her vocational profile, work restrictions and unsuccessful job search. However, Ragains also opined that Petitioner could be vocationally rehabilitated and gainfully employed if she were given the opportunity to undergo skills training at a local community college. Specifically, he recommended Petitioner be enrolled in a program for an Office Professional Assistant, a 61 hour program that would lead to an Associate degree. Given the fact that Petitioner was 54 years of age at the time of Ragains' evaluation, he recommended that any retraining program be short (Petitioner's Exhibit 9).

Respondent declined to authorize or pay for the rehabilitation program recommended by Ragains. Instead, Respondent had Petitioner evaluated by Amanda Ortman, a vocational expert, on November 19, 2014. In connection with her evaluation of Petitioner, Ortman reviewed medical records/reports, the FCE and Ragains' vocational report dated September 12, 2013. In addition to her employment history, Petitioner also advised Ortman that she volunteered as a radio announcer on Monday mornings.

In Ortman's initial report dated November 19, 2014, she stated that she performed a transferability skills analysis using the OASYS and listed eight jobs in the food service industry and two office positions for which she opined Petitioner was employable. She stated that she would initiate job placement services for Petitioner; however, in her supplemental reports dated January 6, and February 9, 2015, she noted that job placement services had not been authorized (Respondent's Exhibit 1).

At the request of Petitioner's counsel, Ragains reviewed Ortman's report of November 19, 2014. In a supplemental report dated November 28, 2014, Ragains disagreed with Ortman's conclusions and recommendations. Initially, he noted that Petitioner had conducted a comprehensive and diligent job search for work that was included in the list of jobs recommended by Ortman as well as other employment. He also noted that Ortman's statement that all 10 positions were listed in the "Dictionary of Occupational Titles" (DOT) was not accurate in that three of the 10 positions were not, in fact, listed in the DOT.

Ragains also noted that for Petitioner to work as a kitchen supervisor (one of the 10 jobs in Ortman's list) Petitioner would have to perform tasks contrary to the work restrictions imposed by Dr. Idusuyi (Petitioner's Exhibit 9). In regard to the receptionist position listed in Ortman's list, Ragains opined that for Petitioner to qualify for this position, she would require the additional training that he recommended. Ultimately, Ragains opined that Ortman did not accurately assess Petitioner's employability (Petitioner's Exhibit 9).

At trial, Petitioner testified that she met with Ortman several times and applied for all of the positions that Ortman recommended. The singular exception to this was a job as a bus driver. Petitioner stated that she did not apply for that job because it would have required extensive use of her feet when driving the bus. Further, Petitioner applied for other jobs in addition to those provided to her by Ortman.

When Petitioner met with Ortman on March 15, 2015, she advised that she had applied for the position of Food Service Administrator I with Respondent, and this was a position she had previously held for eight and one-half years. Petitioner was interviewed for this position.

Geoffrey Evans, Respondent's Director of Food and Dining Services testified at trial. Evans interviewed Petitioner for the Food Service Administrator I job in April, 2015. Evans knew Petitioner because he was her supervisor when she managed Respondent's coffee shop sometime ago. Evans stated he did not ask Petitioner any questions about her physical restrictions and that they would have been assessed at a later time. Evans said Petitioner informed him of her foot condition and her work restrictions even though he had not asked her any questions regarding same.

On cross-examination, Evans agreed that the Food Service Administrator I position required standing for long periods of time, carrying of food items, food preparation, lifting of heavy boxes of food, etc. Evans did not make a recommendation that Petitioner be hired and the job was not offered to her.

Petitioner also testified that she hosted a radio show on Monday mornings at a local station. Petitioner is on the air approximately three to four hours on Monday mornings and this is apparently some sort of talk show. This is a volunteer position and Petitioner receives no income from it.

Ragains testified at the trial. His testimony was consistent with his reports and he reaffirmed the opinions contained therein. In regard to Petitioner informing a potential employer of her work restrictions, he stated that this was appropriate for Petitioner do so once she determined that the job for which she had applied would require accommodations. He also opined that many of the jobs recommended by Ortman were not appropriate for Petitioner because of her restrictions, skills or a combination of both.

Regains testified that Petitioner could not work in the food service industry because these jobs required Petitioner to be on her feet for most of a workday and many of the positions required lifting in excess of Petitioner's restrictions. He also stated Petitioner had put forth a diligent and good faith effort to find suitable employment.

Ortman testified at trial and her testimony was consistent with her reports and she reaffirmed the opinions contained therein. Ortman opined that Petitioner was employable in a sedentary/light duty position in an office type environment; however, she could not identify any current positions which would be appropriate for Petitioner nor did she prepare a labor market survey which indicated that such positions were readily available.

Ortman also questioned the diligence of Petitioner's attempts to secure employment and opined that she was not going to interviews with the proper attitude. She specifically referenced Petitioner's interview with Respondent for the Food Service Administrator I position. She also stated that, as part of her job placement services, she had set up an e-mail address for Petitioner to use for communication with potential employers. She stated that when she checked on Petitioner's use of e-mails, there were approximately 100 e-mails that Petitioner did not open. This was for a period of approximately two weeks and was towards the end of her providing job placement services to Petitioner.

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

The Arbitrator concludes that Petitioner is permanently and totally disabled as result of the injury she sustained.

In support of this conclusion the Arbitrator notes the following:

It was undisputed that Petitioner sustained a serious injury to her right foot/ankle on February 17, 2012. Significant permanent work/activity restrictions were imposed by Petitioner's treating physician, Dr. Idusuyi.

The fact that Petitioner was unable to return to work to the job she had at the time of the accident because of her permanent work/activity restrictions was not disputed by Respondent.

Petitioner began her own self-directed job search in October, 2013, and the records of her job search were tendered into evidence at trial. The Arbitrator reviewed the records and noted that they were very extensive.

Counsel for both Petitioner and Respondent retained vocational experts, James Ragains and Amanda Ortman, respectively. Both of these vocational experts testified at trial.

Ragains opined that, because of Petitioner's work/activity restrictions, she could not return to work at the job that she had at the time of the accident nor could she return to work to jobs in the food service industry. He also opined that Petitioner lacked transferability of skills.

Ragains reviewed Petitioner's documentation regarding her job search and opined that it was the most diligent, well documented and comprehensive job search that he had ever seen. He opined that Petitioner could be vocationally rehabilitated and gainfully employed if she received skills training at a local community college. However, Respondent declined to offer this training to Petitioner and referred her to their expert, Amanda Ortman.

Ortman recommended Petitioner seek employment for a number of jobs which were not consistent with Petitioner's work/activity restrictions, including several food service positions and driving a bus. This was specifically noted by Ragains.

While Ortman opined that Petitioner could return to work in a sedentary/light duty office type position, she could not identify if any such positions were actually available nor did she prepare a labor market survey.

In regard to Petitioner's alleged noncompliance with vocational experts, the Arbitrator does not find Petitioner's advising Geoffrey Evans of her work/activity restrictions during the interview process to be a deliberate act on her part to not obtain employment. As was noted by Ragains, this disclosure was appropriate for Petitioner to make during the interview process because of the physical demands of that job in the food service industry.

Given Petitioner's diligent and comprehensive job search, the Arbitrator does not find Petitioner's not opening e-mails during the last two weeks of Ortman's job placement services to be of any particular significance.

Petitioner's unpaid volunteer position at a local radio station is not evidence of her ability to obtain employment in a reasonably stable labor market and is likewise of no particular significance.

The Arbitrator finds the opinions of Ragains to be more persuasive than those of Ortman.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EDDIE HUCKELBERRY,

Petitioner,

vs. NO: 10 WC 18892

MONTEREY MUSHROOMS,

16IWCC0372

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, notice, medical, causal connection, temporary total disability (TTD), permanent partial disability (PPD), and "choice of physicians," and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Eddie Huckelberry established that he sustained a work-related accident arising out of and in the course of his employment on May 19, 2009.

As the result of the accident, Huckelberry is entitled to TTD benefits from June 3, 2009 through July 16, 2009 and October 20, 2010 through December 5, 2010, representing 13-5/7 weeks. The Petitioner is entitled to reasonable and necessary medical expenses totaling $44,083.21. Monterey Mushrooms (Respondent) is entitled to a credit of $23,572.36 representing $21,192.36 in medical expenses and $2,380.00 in short term disability, both pursuant to Section 8(j) of the Act. The Commission finds Huckelberry sustained twenty percent loss of use of the man-as-a-whole pursuant to Section 8(d)(2) of the Act.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties.

16IWCC0372

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Per the Application for Adjustment of Claim filed May 17, 2010, Eddie Huckelberry was a 54 year old, single male with no dependants under the age of 18. Huckelberry alleged injury to his person-as-a-whole while performing his job duties on May 19, 2009.

2. Huckelberry began working for Respondent as a truck driver in the winter of 2008. T.12. He last worked for the Respondent on January 8, 2014. T.13.

3. Huckelberry testified that he had a prior back issue but it did not keep him from working. T.14. He would occasionally see Dr. Martin, a chiropractor, and treated at Farrell Chiropractor. He also sustained an injury to his low back in a car accident in the middle 1970s. T.15.

4. Pursuant to respondent's exhibit 1, petitioner was seen on October 27, 2007 for low back pain, neck pain and stiffness and pain between the shoulders, and pain or numbness in the hips. He also had pain in his stomach. RX.1.

5. On September 22, 2008, it was noted that petitioner fell on steps in the winter in 2006. He fell straight back and landed on the backside of an edge of a step. He had pain in the low back mostly over the PSIS. The pain traveled into the right leg. RX.2.

6. On May 19, 2009, Huckelberry had an issue with the trailer tarp on his work truck. He climbed onto the back of the trailer and lost his balance causing him to slip around backwards. He hit the middle of his lower back against a metal motor bracket that controlled the tarp. T.17. He hit between 5 to 6 inches above the belt line and experienced immediate pain. T.18. Petitioner testified that he felt like he did something "real good this time." *Id.* He sat there for an hour and talked to Kevin, who was the person at the racetrack that was loading the trailer. T.19. The following day he informed the company dispatcher, Louis Delgato of his injury. T.20. Petitioner thought he could work off his issues. T.21.

7. Mr. Terry Johnson is the distribution manager for respondent and supervised Huckelberry. T.46. He stated that Huckelberry never reported back pain to him, but he was aware that Huckelberry was off work due to an injury. T.47. On cross-examination, Johnson testified that he had no reason to dispute that Huckelberry reported the accident to Louis Delgato. T.51. However, Mr. Delgato never mentioned petitioner's condition to him. T.51. Johnson testified that an incident report was completed, but it was handled by Mr. Delgato.

8. Petitioner presented to Dr. Martin on May 22, 2009 and reported that he seemed to aggravate his right lower back and had severe pain. Then on May 27, 2009, Dr. Martin noted petitioner had continued right lower back pain and tightness. RX.1.

9. Huckelberry presented to Perry Memorial Hospital on June 2, 2009 for radicular pain. The onset was listed as two years ago. It was further noted that Huckelberry's pain worsened 3 weeks ago. He had similar symptoms for 2 years, but he had not recently treated with a doctor. He had right flank pain. He was in no acute distress. The review of systems indicated back pain, and CVA tenderness had a line drawn through it. The impression was right groin pain. PX.1.

10. Petitioner underwent a CT scan of the abdomen without contrast on June 2, 2009 for right flank pain radiating into the right groin. No abnormality was noted. PX.1.

11. Petitioner presented to Perry Memorial on June 5, 2009 for left sided groin pain. He had pain in his right testicle. Back pain was circled in the review of system. He had inguinal tenderness. His back inspection was normal. PX.1.

12. Huckelberry was seen by Dr. Manuel Ascano on June 8, 2009 for right sided back pain radiating down the leg. It was noted that he was pulling a tarp on a trailer and started to feel pain. He had a history of a fall two years earlier. He had back, right groin, and right leg pain. The assessment was lumbar radiculopathy and abdomen pain. PX.2.

13. Huckelberry underwent an MRI of the lumbar spine without contrast on June 8, 2009 at Perry Memorial Hospital. The impression was mild dextroscoliosis of the lumbar spine with degenerative changes. There was a mild right lateral protrusion of the L2-L3 intervertebral disc extending into the right intervertebral foramen. There was mild retrolisthesis at L4 and L5 with evidence of degenerative disc disease and bone marrow edema of the endplates at L3-L4. There was a left lateral protrusion of the L3-L4 intervertebral disc extending into the intervertebral foramen. There was a mild bulging disc at L4-L5 and a diffuse bulge at L5-SI extending into the right intervertebral foramen producing right side neural foraminal stenosis. PX.1.

14. Petitioner underwent an MRI of the lumbar spine with gadolinium on June 11, 2009 at Perry Hospital. The MRI revealed a mild lateral protrusion at L2-L3 extending into the right L2-L3 foramen. There was mild retrolisthesis at L3-L4 with left lateral protrusion of the L3-L4 intervertebral disc into the foramen and a diffuse bulging disc at L4-L5 and L5-SI. At L5-SI level, the disc extended into the right intervertebral foramen producing right sided neural foraminal stenosis. PX.1.

15. Petitioner presented to Perry Memorial on June 12, 2009 for severe right groin pain. Petitioner underwent a CT scan of the abdomen that revealed mild sigmoid diverticulosis. The abdomen and pelvis was otherwise unremarkable. PX.1.

16. Dr. Deofil Orteza authored a report to Dr. Ascano on June 12, 2009. Dr. Orteza noted petitioner was seen for right low back pain, right groin pain, and right testicular pain. Petitioner reported an 11 day history of severe right low back pain with significant radiation down to his right groin and right testicular area. His pain was constant and 10 out of 10. Dr. Orteza noted that the most significant factor that may correlate to petitioner's symptoms was the L2-L3 right lateral protrusion of the intervertebral disc. The impression was right low back pain with significant radicular pain into the projection of the right groin and right testicular areas that was secondary to his intervertebral disc protrusion at L2-L3. Dr. Orteza recommended an epidural injection. Dr. Orteza noted that if the injection provided relief, it would then indicate that the cause of petitioner's pain was related to his degenerative disc disease at L2-L3. If there is no improvement following the injection, then other causes of his pain would need to be investigated. PX.2.

17. Petitioner was seen by Dr. Ascano on June 17, 2009. He had an epidural with no relief. He had severe pain in the right testicle. PX.2.

18. Dr. Mark Williams authored a letter to Dr. Manuel Ascano on June 22, 2009. Dr. Williams noted that petitioner was examined for a right inguinal hernia with severe pain and a feeling that his whole right side locked up. Dr. Williams noted that the hernia was likely not the cause of petitioner's primary complaints. Dr. Williams recommended an evaluation for sciatica. PX.2.

19. Huckelberry was seen by Dr. Gerald Levisay of Illinois Urologic Health Surgeons on June 22, 2009. Dr. Levisay noted that the CT scan was unremarkable. The MRI of the back revealed a bulging disc. Petitioner reported that his pain was excruciating in the right lower quadrant, right groin, and right testicle. There was evidence of an inguinal hernia. The impression was right groin strain/pain secondary to a herniated disc. His pain was of "other" etiology. The injection did not alleviate his pain. PX.2.

20. Petitioner was seen by Dr. Jeffrey Dickhut for physical therapy on August 3, 2009. It was noted petitioner rode almost 170 miles on his motorcycle over the weekend, which was the first time in a long time. PX.5. Petitioner underwent physical therapy for several months.

21. Petitioner underwent an MRI of the lumbar spine without contrast at Open MRI of McLean County on February 10, 2010. There was a broad based subligamentous protrusion involving L5-SI. A broad based bilobed disc protrusion involving L3-L4 with left foraminal encroachment without evidence of neural compression. There was a broad based non-compressive bulging disc at L4-L5 with underlying discogenic spondylosis and degenerative facet arthropathy. There was also a right posterolatearal disc protrusion that involved the L2-L3 that resulted in abutment of the right L2 exiting nerve root. PX.5.

22. Petitioner presented to Perry Memorial on March 30, 2010 for back pain. The duration was listed as 9 days ago, and it was not a recent injury. His back pain was sharp. His past history included back pain that was chronic and he had an L3-L5 compression fracture in 2009. He also had muscle spasms and decreased range of motion. His straight leg raise was negative. The impression was a lumbosacral strain. PX.1.

23. Huckelberry underwent an EMG on April 21, 2010. It was reported that petitioner had an onset of symptoms while working in April 2009 when he slipped and twisted his back. He had initial swelling in the back and groin, and there was a question of a hernia but the symptoms had progressed to involve the back and legs. He reported pain in the right back that traveled down the leg to the anterior shin with some associated numbness and tingling. The straight leg raise increased his pain. Internal rotation of the right hip caused some pain, but he had full range of motion. The EMG revealed mild right L4 radiculopathy. PX.2.

24. Petitioner underwent a medical examination for commercial driver fitness determination on May 4, 2010. It was noted that Dr. Ascano diagnosed petitioner with low back pain on June 2, 2009. Petitioner had no deformities, limitation of motion, tenderness, or weakness. He was certified for 2 more years. PX.8.

25. Huckelberry was seen by Dr. Min Kyung Kim on May 27, 2010 for lower right sided back pain with numbness, tingling and heaviness in the right leg and hip with sporadic muscle spasms. He has been receiving spinal decompressions 4 times per week with Dr. Dickhut. Petitioner reported that he fell on his lower back while hauling stable bedding and has had lower back pain since the accident. PX.11.

26. On May 28, 2010, Dr. Kim noted that Huckelberry reported that he was at work when he lost his balance and held onto a bar and swung backwards toward the right. He hit the right side of his back on a portion of metal but didn't lose grip on the bar and did not fall onto the ground. It was noted that this was not a workers' compensation case. Petitioner did not receive relief from the epidural injections. The diagnoses were lower back pain, lumbar radiculopathy and lumbar spinal stenosis. PX.11.

27. Petitioner underwent an MRI of the lumbar spine on August 24, 2010 at Illinois Valley Community Hospital. When compared to the June 8, 2009 MRI, there had been slight progressive degenerative disc space narrowing at the L2-L3 disc space with associated retrolisthesis which remained stable. There was new bone marrow edema within the endplates adjacent to the L2-L3 disc space. There was no other significant interval change with the exiting right L4 nerve root being compressed by lateral disc material/osteophytosis within the right L4-L5 neural foramen. PX.2.

28. Huckelberry was seen by Dr. Andrew Ta of Midwest Neurology on October 13, 2010. Petitioner reported injuring himself in May 2009 after falling off a trailer which caused

him to hit his lower back. He began to experience right leg pain following the epidural injection. He still had right sided back pain. The impression was severe lumbar spondylitic disease and disc herniation at L5-S1, and lumbar radiculopathy with intractable back pain. PX.12.

29. Huckelberry was seen by Dr. John Mazur of the Spine Surgery Specialist on October 14, 2010 on referral from Dr. Andrew Ta. Petitioner reported developing low back pain 5 years ago and saw Dr. Jeff Martin in Princeton. He received x-rays and adjustments followed by relief. Then on May 15, 2009, he fell backwards into a motor bracket while at work while adjusting a tarp. Dr. Mazur reviewed the August 24, 2010 MRI which revealed a lot of abnormalities. Most significantly, petitioner had a small right L5-S1 disc herniation that was impinging upon an unusual complex of nerves. The abnormality was congenital but the disc herniation brought on the symptoms. The plan was to decompress the right L5 and right S1 area and map out the adherent nerve roots and remove decompressions, which would probably involve removal of the herniated disc material on the right side at L5-SI. PX.2.

30. Dr. Mazur performed a right L5 and right SI micro hemilaminectomy, partial facetectomy, foraminotomy and microdissection, and right L5-SI discectomy on October 20, 2010. PX.2.

31. Petitioner was seen by Dr. Mazur on December 2, 2010. The back incision was well healed and he had good strength in his lower extremities. Petitioner reported that he had "worms" coming out of his skin. He had a return of low back pain and right hip pain two weeks after the surgery. Petitioner did not have physical therapy due to his skin problems and cramps in the right thigh and calf. Dr. Mazur noted that petitioner would not have good surgical results if he did not soon get active. Petitioner was returned to work without restrictions on December 6, 2010. PX.2.

32. Dr. Mazur was deposed on August 8, 2014. Dr. Mazur is board certified in nuerological and spine surgery. He diagnosed petitioner with a disc herniation on the right side at L5-S1 which was compressing the right SI nerve root and/or the right L5 nerve root. There were probable adherent nerve roots, congenital variations and a degenerated right L5-SI facet joint. PX.17. pg.12. Dr. Mazur concluded that the disc herniation was precipitated by the work injury and was the cause of petitioner's symptoms. *Id.* He stated that the surgery was reasonable.

33. Dr. Mazur performed the surgery on October 20, 2010 and noted there was scar tissue, which could have been caused by the disc herniation and the epidural injections. There was an indentation from the disc herniation which point posteriorly. PX.17. pg.16. Dr. Mazur stated that it was more likely than not that the disc herniation impinged the L5 nerve root and caused his symptoms. The surgical findings were consistent with the MRI findings and consistent with the history petitioner provided.

34. Huckelberry was seen by Dr. Robert Eilers on August 16, 2011. Dr. Eilers diagnosed petitioner with an L5-S1 right herniated nucleus pulposus secondary to work injury on 5/19/209 causing and/or aggravating the disc herniation resulting in symptoms. He had myofascial pain syndrome involving the lumbosacral paraspinal and the tensor fascia lata, right greater than left, secondary to strain-sprain injury component occurring on May 19, 2009. There was an aggravation of the underlying degenerative arthritis and facet arthritis in his right lumbosacral spine and the lumbosacral paraspinals. There was also significant aggravation of the disk bulges and L5-S1 disc herniation. The chronic pain was related to his right lumbar disc herniation. Dr. Eilers noted that the lumbar disc surgery at L5-S1 was the direct and proximate cause of his work injury, which either caused or significantly aggravated the disc herniation. It resulted in nerve root impingement on the right. The treatment had been reasonable and appropriate. Petitioner was able to function adequately prior to the accident but was now limited to light sedentary work. PX.18.

35. Dr. Eilers was deposed on November 12, 2012. PX.18. Dr. Eilers is board certified in physical medicine rehabilitation. He diagnosed petitioner with an L5-SI right sided herniated nucleus pulposus that arose out of his May 19, 2009 injury, which caused or aggravated the disk herniation. The injury caused the symptoms for which petitioner was treated. Huckelberry had myofacial pain as a result of the injury. The tenor fascia lata of the right was more involved than the left, which also arose out of his injury. Petitioner also had an aggravation of underlying degenerative arthritis and disc herniation. He had some continued chronic pain related to the disc herniation. He had a loss of his functional abilities within his job.

36. Respondent obtained a Section 12 examination from Dr. Andrew Zelby of Neurological Surgery & Spine Surgery on January 23, 2012. Huckelberry reported that he fell backwards and to the right striking the right side of his lower back on a motor bracket. Dr. Zelby diagnosed petitioner with lumbosacral spondylosis and a herniated lumbar disc. Dr. Zelby noted that when petitioner first sought treatment for his complaints, he indicated that the symptoms had been present for two years with worsening of symptoms three weeks earlier. He did not describe any work incident as the cause for his worsening of symptoms. He reported symptoms and groin pain that began after pulling of the trailer tarp. Dr. Zelby noted that the symptoms may have been referable to the right L1-L2 disc protrusion, but had nothing to do with any disc abnormality at L5-S1. There were also symptoms petitioner reported that he been present since a fall two years earlier. Dr. Zelby opined that Petitioner's condition was not caused or even symptomatic as a result of his subsequent report of a work injury. The symptoms had been present long before petitioner began his job. The symptoms were completely unrelated to the L5-S1 dermatome. The discectomy was not a consequence of the surgery. All of petitioner's treatment after August 2009 was not a consequence of any work event. He could continue to work full-duty. RX.3.

37. Dr. Zelby was deposed on January 16, 2013. Dr. Zelby is board certified in neurosurgery. He noted that petitioner reported that his symptoms of pain had been present since a fall two years earlier but had gotten worse over the preceding three weeks. RX.3. pg.13. He reviewed the MRI from August 24, 2010 and diagnosed petitioner with lumbosacral spondylosis and a herniated lumbar disc. RX.3. pg.17. Petitioner did not describe any twisting just that he slipped as he was pulling a tarp. RX.3. p.g18. Dr. Zelby noted that the first medical record following the alleged accident made no mention of a work accident and that he had pain for two years, which was not consistent with what petitioner stated. *Id.* Dr. Zelby testified that petitioner was capable of working full duty. He found no relation between the reported injury and the surgery. The symptoms of the L5-SI herniated disc had no resemblance to any of the symptoms reported. Dr. Zelby found it hard to say petitioner sustained any injury as petitioner indicated that the symptoms had been present for two years. Petitioner's symptoms had been present long before he began his job. RX.3. pg.21. However, Petitioner did not report any prior episodes or similar symptoms. The chiropractic treatment and surgery was not related to the accident.

38. On cross-examination, Dr. Zelby noted there was no duration mentioned as to the onset of back pain. RX.3. pg.28. He stated that the ER record from June 2, 2009 indicated that petitioner had no CVA tenderness. He noted that petitioner did report an accident on June 8, 2009 to Dr. Ascano. He stated that petitioner's symptoms had nothing to do with the L5-SI level. RX.3. pg.44. It was anatomically obvious they were unrelated.

39. Huckelberry testified that he worked from December 2010 through January 2014 as a truck driver. He continued to experience his regular issues with his leg and back. T.38. In January 2014, he stopped working as he could no longer perform his duties. T.39. He was losing his reflexes. Petitioner stated that he cannot work due to his reflexes and muscles on his right side. He has pain and discomfort, and everything is tight. T.42. He performs therapy at home. He tries not to take pain medication. T.43. His pain is the same today as it was at the time of the accident. T.44.

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. *R.A. Cullinan & Sons v. Industrial Comm'n*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240, 159 Ill. Dec. 180 (1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Department v. Industrial Comm'n*, 83 Ill. 2d 528, 533-34, 416 N.E.2d 243, 245, 48 Ill. Dec. 212 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Industrial Comm'n*, 51 Ill. 2d 533, 536-37, 283 N.E.2d 875, 877 (1972).

For an accidental injury to be compensable under the Act, a Petitioner must show such injuries arose out of and in the course of his employment. *Eagle Discount Supermarket,* 82 Ill. 2d at 337-38, 412 N.E.2d at 496; *Nabisco Brands, Inc. v. Industrial Comm'n,* 266 Ill. App. 3d 1103, 1106, 641 N.E.2d 578, 581, 204 Ill. Dec. 354 (1994)."Arising out of" refers to the requisite causal connection between the employment and the injury. In other words, the injury must have

had its origins in some risk incidental to the employment. See *Eagle Discount Supermarket,* 82 Ill. 2d at 338, 412 N.E.2d at 496; *William G. Ceas & Co.,* 261 Ill. App. 3d at 636, 633 N.E.2d at 998. "In the course of" refers to the time, place, and circumstances under which the accident occurred. See *William G. Ceas & Co.,* 261 Ill. App. 3d at 636, 633 N.E.2d at 998. Whether the claimant suffered from a compensable accident is a question of fact to be determined by the Commission. *National Freight Industries v. Illinois Workers' Compensation Comm'n,* 2013 IL App (5th) 120043WC, ¶ 26, 993 N.E.2d 473.

The Commission finds that Huckelberry sustained an accident arising out of and in the course of his employment, and that his condition is causally related to the work accident.

In support of its finding, the Commission notes that the Arbitrator's denial of the claim was based, in part, upon his finding that Huckelberry was not credible. The Commission, however, finds that the evidence does not support the arbitrator's finding. The arbitrator noted that "the first records from Perry Memorial Hospital on June 2, 2009 also fail to mention any work accidents, despite a rather clear description of petitioner's groin pain." The Commission, however, notes that this emergency room record is mainly a pre-printed form with boxes that were checked off. The Commission notes that the record indicated that petitioner's pain had been worse for the past three weeks and that petitioner has not been seen by a doctor recently. While there is no mention of a work injury, there is indication of back pain and the three week duration of pain is consistent with the timing of his accident.

Further, when petitioner was seen by Dr. Ascano on June 8, 2009, Ascano noted that petitioner's back pain began while pulling a tarp. Petitioner then went to the ER a few days later. The Commission finds this record consistent with petitioner's testimony regarding his accident. Also, the vast majority of medical records provide a consistent history of accident and onset of symptoms.

Furthermore, the arbitrator noted that Dr. Kim indicated in his May 2010 record that this was not a workers' compensation case. However, this same record provided a very detailed history of a work-related accident. Dr. Kim's record from the day prior noted that petitioner had a work accident in May 2009 and has had pain ever since. There is no evidence in any of Dr. Kim's records that petitioner's symptoms are related to anything but the work injury.

Additionally, the arbitrator noted that Dr. Mazur related the condition to a traumatic event on May 15, 2009 while Dr. Eilers related it to a May 19, 2009 incident. The arbitrator noted that based upon the inconsistent medical evidence, "this was too great to ignore." After reviewing all of the medical records, the Commission does not find this discrepancy significant in light of the totality of the evidence.

The Commission also finds Mr. Johnson's testimony supportive on the issue of accident. Mr. Johnson was aware that petitioner completed an incident report and was off work due to an

injury. The incident report, however, was handled by Mr. Delgato. Mr. Delgato was not called as a witness and the incident report was not offered into evidence.

The Commission is not persuaded by Dr. Zelby's opinion. Dr. Zelby essentially ignored the fact that the history of accident was referenced in the June 8, 2009 accident and that petitioner had no documented symptoms prior to the accident. Rather, Dr. Zelby's opinion was premised upon the belief that petitioner had symptoms for two years prior to the accident. His opinion is directly contradicted by the evidence. The records indicate that petitioner's pain had worsened within the past three weeks, which is in conformance with the timing of the accident. His opinion also ignores petitioner's un-rebutted testimony that he was able to work full-duty and without restriction up until the May 19, 2009 accident. Consequently, the Commission finds the opinion of Dr. Mazur more persuasive. Dr. Mazur concluded that the disc herniation was the cause of petitioner's symptoms, which was caused by the work accident.

Accordingly, the Commission finds that, based upon petitioner's testimony together with the medical records, Huckelberry established that he sustained a work-related accident arising out of and in the course of his employment on May 19, 2009 and that his current condition of ill-being is causally related to said accident.

Consequently, Petitioner is entitled to TTD benefits for 13-5/7 weeks from June 3, 2009 through July 16, 2009 and October 20, 2010 through December 5, 2010. He is also entitled to medical expenses totaling $44,083.21. Respondent is entitled to a credit of $23,572.36, which represents $21,192.36 in medical expenses and $2,380.00 in short term disability, both pursuant to Section 8(j) of the Act.

The Commission finds Huckelberry is entitled to 20% loss of use of the man-as-a-whole. Petitioner underwent a right L5-S1 micro hemilaminectomy and right L5-S1 discectomy. Huckelberry was able to perform his work duties until January 2014 at which time he voluntarily left his job due to his alleged ongoing pain. He testified that he has some residual pain which impacts his daily activities. The Commission is not convinced that Petitioner's current inability to work is the result of this accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that that the Decision of the Arbitrator, filed on May 12, 2015, is hereby reversed as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $645.37 per week for a period of 13-5/7 weeks (June 3, 2009 through July 16, 2009 and October 20, 2010 through December 5, 2010), 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 $580.83 per week for a period of 100 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused the 20% loss of use of the person-as-a-whole.

16IWCC0372

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay all medical expenses pursuant to Sections 8(a) & 8.2 of the Act. Respondent shall have credit for amounts paid under Section 8(j) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: JUN 6 - 2016

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
D: 5/16/16
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUCKELBERRY, EDDIE E
Employee/Petitioner

Case# 10WC018892

MONTEREY MUSHROOMS
Employer/Respondent

16IWCC0372

On 5/12/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0400 DAVID W OLIVERO
1615 4TH ST
PERU, IL 61354

1120 BRADY CONNOLLY & MASUDA PC
SURABJI SARASWAT
10 S LASALLE ST SUITE 900
CHICAGO, IL 60602

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

EDDIE E. HUCKELBERRY
Employee/Petitioner

v.

MONTEREY MUSHROOMS
Employer/Respondent

Case # **10 WC 18892**

Setting: New Lenox

16IWCC0372

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

DISPUTED ISSUES

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

FINDINGS

16IWCC0372

On **5/19/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was*** 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 $**18,538.10**; the average weekly wage was $**968.05**.

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

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

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

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

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

ORDER

Petitioner has failed to meet his burden of proof on the issue of accident. Therefore, the claim is denied.

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

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

Signature of Arbitrator

5/11/15
Date

MAY 12 2015

FINDINGS OF FACT

Petitioner is alleging an injury arising out of his employment on May 19, 2009. Respondent is disputing the following issues: 1) accident, 2) notice, 3) causation, 4) medical expenses, 5) TTD, 6) permanency and 7) whether the Petitioner exceeded his two choices of doctors.

Petitioner began working for the Respondent in 2008 as a truck driver. He would haul sable bedding, straw waste to be used for compost at the farm. Prior to his employment with Monterey Mushrooms, Petitioner sold motorcycles for a Harley Davidson shop. He testified that he has treated with chiropractors Dr. Martin and Dr. Farrell in the past for back pain. He further testified that he was involved in a car accident sometime in the 1970's and injured his low back.

At trial, Petitioner testified that on May 19, 2009, he was driving a truck when the tarp on the trailer came loose. He manually pulled the tarp, losing his balance, spinning around and hitting the middle of his back on the motor bracket. He testified that his low back hit the electric motor approximately 5 to 6 inches above his belt line. Petitioner was able to continue working the remainder of the day. The next day, he reported the incident of his spinning around on the tractor to the dispatcher, Luis Delgado.

Three days after the incident, Petitioner was seen by his regular chiropractor, Dr. Martin. Petitioner testified at trial that he told Dr. Martin what caused his injury. Dr. Martin's May 22, 2009 and May 27, 2009 records have no history of a trauma, work-related or otherwise, and indicate petitioner simply complained of right low back tightness and spams during both his visits. (RX 1) Petitioner testified that the chiropractic treatment did not help but he was still capable of working full duty.

On June 2, 2009, Petitioner reported to Perry Memorial Hospital. (PX 1) Petitioner reported testicular, right flank and back pain with an onset of two years ago. Petitioner returned to Perry Memorial Hospital on June 5, 2009, June 8, 2009 and June 12, 2009 for groin and back pain. There is no mention of any history of work injury in records from this provider.

On June 8, 2009, Petitioner saw his primary care physician, Dr. Ascano. (PX 2) Dr.Ascano's records from that day, include a history of the Petitioner pulling a tarp on top of a trailer when he started to feel pain in the right groin. Dr. Ascano prescribed vicodin for the Petitioner's back pain. On June 11, 2009, Dr. Ascano diagnosed Petitioner with degenerative disc disease, lumbar radiculopathy and referred Petitioner to Dr. Orteza. On June 12, 2009, Dr. Orteza reviewed Petitioner's lumbar MRI and noted that the most significant findings that may correlate to the patient's symptoms would be the L2-3 right lateral protrusion of the intervertebral disc extending into right intervertebral foramen. (PX 3) He gave Petitioner two epidural injections: on June 12, 2009 at the L1-2 level; and June 26, 2009 at the T12-L1 level. Dr. Orteza noted that clinically the pain had improved even though petitioner continued to complain of his testicles retracting into his groin area with pain. There is no mention of any work injury in Dr. Orteza's records.

On July 2, 2009, Petitioner saw chiropractor Jeffrey Dickhut, DC. The initial records from this medical provider include a history of Petitioner straining his groin area when he had to get on a trailer 5 weeks ago, wherein Petitioner's "right testicle sucked up inside his body." (PX 5) On August 28, 2009, Dr. Dickhut provided a work status note indicating that Petitioner had light duty restrictions of no lifting more than 40 pounds from the floor, no pushing or pulling more than 50 pounds and only working 5 hours a day with mobility every 30 to 40 minutes. Dr. Dickhut related these restrictions to a flare-up of lumbar degenerative disc disease. On September 24, 2009, Dr. Dickhut released Petitioner back to work without restrictions. Petitioner was later

given work restrictions by Dr. Dickhut on February 11, 2010. Petitioner continued treating with Dr. Dickhut through September, 2009 for low back and leg pain. However, the records from this provider do not mention any work related accident history. Dr. Dickhut referred petitioner to a neurologist Dr. Carmichael of McLean County Orthopedics.

On April 21, 2010, Petitioner saw Dr. Carmichael for an evaluation of right back and leg symptoms. (PX 7) Dr. Carmichael's records from that date include a history in which the Petitioner reports an onset of symptoms when he was working in April, 2009. According to the Petitioner's history, he "was helping to obtain some bedding material from a race track, when he slipped and twisted his back. Initially, he had swelling in his back and groin and there was a question of a hernia, but the symptoms have progressed to involve the back and leg."

On May 19, 2010, Petitioner was seen by Dr. Leonard Cerullo on referral from Dr. Ascano. (PX 10) He reported that a year ago while driving a tractor trailer with stable bedding he lifted a tarp, slipped and fell backward, striking his low back and developed severe pain in the low back, right lower quadrant, and abdomen. Over the next days he experienced right leg stiffness and finally went to the emergency room on June 2, 2009. Dr. Cerullo felt that petitioner had failed conservative treatment and was a surgical candidate.

On May 28, 2010, Petitioner saw Dr. Kim for pain management related to Petitioner's complaints of low back pain first noted in May, 2009. Petitioner testified at trial at he was referred to Dr. Kim by Dr. Ascano. However, Dr. Kim's initial records indicate a referral referral from Dr. Dixon. Dr. Kim's records from May 28, 2010 indicate: "This is not a work comp case and patient states he had been going to his PCP for treatment...His chiropractor sent him to see Dr. Cerullo. Dr. Cerullo referred him to Dr. Dixon who recommended surgery." Dr. Kim ultimately provided Petitioner with epidural steroid injections. Dr. Kim's records also include a progress note from Dr. Dixon dated September 23, 2010. In that progress note, Dr. Dixon notes that the Petitioner relieved his right back and leg pain by "rubbing" the skin and "releasing" the tightness of the muscles. Further in that progress note, Dr. Dixon indicates in his assessment that the Petitioner "is engaging in compulsive behavior that is not consistent with the imaging or EMG findings and that a surgical intervention is not advisable at this point."

On October 13, 2010, Petitioner saw Dr. Ta of Midwest Neurology. Dr. Ta's record from that date include a history of the Petitioner injuring himself on the job around May, 2009, when he fell off a trailer, hitting his lower back. Dr. Ta notes Petitioner's complaints of pain radiating down into his right foot. Dr. Ta's impression was spondylitic disease and disc herniation at L5 and S1 with lumbar radiculopathy and intractable back pain. Dr. Ta prescribed Petitioner Elavil and referred him to Dr. Mazur.

Petitioner was first seen by Dr. Mazur on October 14, 2010 for right sided low back pain with radiation into right hip, anterior thigh anterior medial lower leg. (PX 17) Dr. Mazur notes in Petitioner's history that on May 15, 2009, Petitioner fell backwards into a bracket motor on his trailer while adjusting a tarp. Dr. Mazur ultimately performed surgery on Petitioner involving a right L5-S1 micro-hemilaminectomy, partial facetectomy, foraminotomy and microdissection and right L5-S1 discectomy and C-arm fluoroscopy manipulation on October 20, 2010. Dr. Mazur also placed petitioner off of work as of October 14, 2010 for approximately 8 weeks. Dr. Mazur released petitioner back to work without restrictions on December 2, 2010. Dr. Mazur testified via evidence deposition on August 8, 2015. (PX 17) Dr. Mazur testified that the Petitioner's surgery was successful and that he had no work restrictions following the surgery. Dr. Mazur opined that the Petitioner's back condition was related to the May 15, 2009 incident when Petitioner fell

backwards into a bracket motor.

Petitioner testified that he returned to work following the December 2, 2010 release by Dr. Mazur in his capacity as a truck driver. He also testified that January 2014, he became frustrated again and chose to stop working. Petitioner indicated that no doctor had placed him off of work and he could not specifically indicate what functions of his job he was unable to perform. Petitioner testified that he last worked for Respondent on January 8, 2014 and has not worked anywhere since leaving his employment with Monterey Mushrooms. He was not seeing any doctor or chiropractor at the time of trial. Petitioner received short term disability benefits for the time period that he was off of work. Petitioner testified that he is unable to work due to his reflexes and the muscles on his right side of the body. Petitioner is self-treating with a retired doctor who taught him how to treat himself with pressure points. He is not currently taking any pain medication and is not working in any capacity. Throughout his normal day, he testified that he mostly gets frustrated, tries to do what he can but he is limited in what he can do without providing any specifications as to what activities or hobbies he was unable to do. Petitioner testified that he is currently on social security disability.

Terry Johnson testified on behalf of the Respondent. Mr. Johnson testified that he was employed as a distribution manager with Respondent since 2006. He was Petitioner's supervisor throughout Petitioner's employment with Respondent. Mr. Johnson testified that Petitioner did not report any back pain to him between January of 2011 and January of 2014. Further, Petitioner never reported that he had any difficulty performing any of his job duties. On cross-examination, Mr. Johnson confirmed that he became aware of Petitioner's back pain after Petitioner submitted an incident report to his manager, Mr. Delgato.

Dr. Zelby testified via evidence deposition on January 16, 2013. (RX 3) Dr. Zelby conducted an IME at the request of Respondent on January 23, 2012. Dr. Zelby opined that he did not believe Petitioner's back condition was related to the incident he described from May, 2009. Dr. Zelby supports his opinion with reference to the initial medical records that indicate Petitioner had similar physical complaints pre-dating the accident date and that there is no mention of any work accident in the Petitioner's initial medical histories. Dr. Zelby further opined that there was no competent reason for the Petitioner to have undergone the surgery performed by Dr. Mazur.

Dr. Eilers, testified via evidence deposition on November 12, 2012 that he performed an independent medical evaluation at Petitioner's request. (PX 18) Dr. Eilers testified that Petitioner had a L5-S1 right sided herniated nucleus, which was either caused or aggravated by the Petitioner's accident on May 19, 2009. He believed that the Petitioner's injury on May 19, 2009 involved him twisting his back. He also testified that Petitioner was limited to sedentary activities and would not be able to climb on rigs, clean out trailers, and climb ladders.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. This finding is based primarily on the Petitioner's lack of credibility. In support of this finding, the Arbitrator relies on the Petitioner's testimony and the conflicting histories of the various medical providers. At trial – over 6 years since the alleged accident date - Petitioner was able to clearly describe what transpired on May 19, 2009, when he lost his balance while on a trailer and fell onto the motor, striking his lower back above his belt line. The history provided by Petitioner at trial is markedly absent from his visit to Dr. Martin for back treatment on May 22, 2009. The first records from Perry Memorial Hospital on June 2, 2009 also fail to mention any work accident, despite a rather clear description of Petitioner's groin pain. There is an even more graphic description of Petitioner's groin pain in Dr. Orteza's records, but there is no mention of a work injury in

his June, 2009 records. When Petitioner sees Dr. Dickhut in July, 2009, there is some mention of getting on a trailer at work 5 weeks ago and there is a painfully vivid description of Petitioner's retracting groin pain, but there is no clear description of what happened at work. By the time Petitioner gets to Dr. Carmichael in April, 2010, the history of the accident begins to sound like what the Petitioner described a trial, but it indicates the accident occurred sometime in April, 2009. To confuse matters more, Dr. Kim indicates in his May, 2010 records that "this is not a work comp case." Petitioner's own surgeon, Dr. Mazur testified that he relates Petitioner's condition to what appears to be a traumatic incident occurring on May 15, 2009, as compared to the Petitioner's IME, Dr. Eilers who relates everything to a twisting accident on May 19, 2009. While the Arbitrator acknowledges that the purpose of a hearing is not to test a witness' memory, the inconsistencies in the medical evidence alone are too great to ignore. As such, the Arbitrator finds persuasive the opinions of Dr. Zelby, who appears to have a complete picture of the Petitioner's inconsistent medical history throughout this case. Given the inconsistencies in the medical evidence and Petitioner's testimony, the Arbitrator concludes that the Petitioner failed to prove that he sustained an accident on May 19, 2009.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Aaron Collier,

Petitioner,

16IWCC0373

vs. NO: 14WC454

United Parcel Service,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 25, 2015, is hereby affirmed and adopted.

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

16IWCC0373

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,200.00. 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: JUN 6 - 2016
o5/25/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0373

COLLIER, AARON

Employee/Petitioner

Case# 14WC000454

UNITED PARCEL SERVICE

Employer/Respondent

On 6/25/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1747 SEIDMAN MARGULIS & FAIRMAN LLP
RYAN A MARGULIS
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY
FRANKLIN B SMITH
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

16IWCC0373

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)

Aaron Collier
Employee/Petitioner

v.

United Parcel Service
Employer/Respondent

Case # **14** WC **00454**

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Chicago**, on **5/02/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

16IWCC0373

On the date of accident, **10/21/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**13,939.64**; the average weekly wage was $**268.07**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **1** dependent children.

Issue of medical bills was reserved by agreement for this 19(b) hearing.

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 $ under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**253.00 (statutory minimum)**/week for **79-2/7** weeks, commencing **10/24/2013** through **5/01/2015**, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for the left shoulder diagnostic arthroscopy pursuant to the Medical Fee Schedule as such treatment is reasonable, necessary and causally related to the subject accident as provided in Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

6/19/15
Date

ICArbDec19(b)

JUN 25 2015

Aaron Collier v. United Parcel Service
14 WC 00454

16IWCC0373

Findings of Fact

The Petitioner, Aaron Collier, had been employed by the Respondent, United Parcel Service, as a package handler since approximately May 2008 or May 2009. The Petitioner testified that his shifts were typically 10:00 p.m. until 3:00 a.m., and consisted of one 10-minute break. The job duties entailed frequent lifting up to 10 pounds, occasional lifting up to 70 pounds, carrying frequently up to 10 pounds, occasionally up to 70 pounds , and pushing/pulling frequently up to 50 pounds, occasionally 100 pounds or more. When unloading packages, he would do so at the rate of 700 to 1300 packages per hour, and 500 to 1200 packages per hour when loading a truck. This information was corroborated by the job description provided to Respondent's Section 12 examiner (R x 1).

The Petitioner testified that he injured his ribs on August 21, 2013 when walking into a pole. He further injured himself on September 23, 2013, when he fell, sustaining injuries to his back. These incidents were noted in the medical records from St. James Hospital – Chicago Heights (R x 5). The Petitioner testified that neither incident involved his left shoulder, and that prior to the subject occurrence, the Petitioner had never had any injuries or medical treatment to his left shoulder.

The Petitioner testified that he presented to work on October 21, 2013 and worked his normal shift until 3:00 a.m. on October 22, 2013. Thereafter, he immediately went home to sleep, and left his house to take a bus at approximately 10:00 a.m. that would arrive in time for school which started at 12:00 p.m. The Petitioner was a computer science major at Chicago State University. His class would end at approximately 2:00 p.m., and then he would take the bus and arrive home around 4:00 p.m.

The Petitioner testified that he would have a backpack with him weighing approximately 10-15 pounds. When putting the back pack on, he would first slide his right arm through and then his left arm. After arriving home, he took off his backpack and felt pain in his left shoulder when removing his jacket. This was the first time the Petitioner felt pain in his left shoulder. He testified that he did not perform any activities after leaving work at 3:00 a.m. on October 22, 2013 other than sleeping and going to class.

The Respondent presented the testimony of three of its employees – Joseph Olsowka, Sylverster Selvie, Jr. and Judith Knabe. Other than Ms. Knabe testifying that the Petitioner told her his backpack was heavy, all three of Respondent's witnesses reiterated in various fashion the identical testimony that Petitioner relayed. Namely, the Petitioner did his normal repetitive heavy duty job from 10:00 p.m. on October 21, 2013 through 3:00 a.m. on October 22, 2013, and did not feel pain in his shoulder until returning home from school.

The testimony of the Petitioner and Mr. Olsowka further corroborated on the Petitioner not presenting to work for his shift that started the evenings of October 22, 2013 and October 23, 2013. When presenting to work on the evening of October 24, 2013, the Petitioner presented the doctor's note concerning his left shoulder and inability to work.

The medical records reveal that the Petitioner first presented to the Emergency Department at St. James Hospital – Chicago Heights on October 24, 2013 (P x 7, R x 5). The history was that of intermittent sharp pains in the left shoulder for the prior 48 hours. It was noted that the Petitioner does a great deal of lifting at work and "may have fallen". When asked about this entry, the Petitioner testified that he told the doctors about the prior incident involving injuring his back when he fell, but did not tell the doctor about falling and injuring his left shoulder.

Thereafter, the Petitioner sought treatment on the same date of October 24, 2013 with Dr. R.R. Veerapeneni, his primary care physician (P x 1). Dr. Veerapeneni notes a consistent history of accident with pain in the left shoulder with stiffness starting on October 22, 2013. It was noted that the Petitioner had been lifting heavy boxes at work on October 21, 2013. A cortisone injection was given. After a few follow-up visits and a suspected bursitis, Dr. Veerapeneni referred the Petitioner to Dr. Venkat Seshadri, an orthopedic specialist.

Dr. Seshadri evaluated the Petitioner on December 10, 2013 noting that the left shoulder "just started to hurt". In a later visit, Dr. Seshadri elaborated by stating that the Petitioner injured his shoulder at work in October 2013. He underwent a second cortisone injection and continued therapy (P x 2). MRI evaluation of November 6, 2013 revealed a normal rotator cuff with mild subacromial/subdeltoid bursitis (P x 5).

The Petitioner testified that due to the lack of payment, he had to seek out a second choice of doctor, choosing Dr. Yazen Joudeh. He first saw Dr. Joudeh on April 22, 2014 (P x 3). Dr. Joudeh's records indicated that he referred the Petitioner to orthopedics and for physical therapy (P x 3). The Petitioner testified that the referral was to Associated Medical Centers of Illinois (AMCI) where he began another course of physical therapy along with the prescription of non-steroidal anti-inflammatory medications (P x 4).

After seeing Dr. Hooton and Dr. Foreman at AMCI, he was referred to that provider's orthopedic specialist, Dr. Thomas Bilko. After the Petitioner failed to improve with physical therapy, Dr. Bilko prescribed a left shoulder diagnostic arthroscopy. That prescription was reiterated through the most recent visit of December 12, 2014 wherein the physical therapy was terminated due to a lack of progress. Dr. Bilko continued the "off work" prescription until such time that the diagnostic arthroscopy could be performed (P x 4).

The Petitioner testified to having continued pain in the left shoulder with activity. He takes pain medications and anti-inflammatory medications twice per day. As of the date of the 19(b) hearing, the Petitioner was awaiting authorization of the diagnostic arthroscopy as physical therapy, medications and cortisone injections failed to relieve his symptoms.

At the request of the Respondent, the Petitioner was seen for a Section 12 examination by Dr. Nikhil Verma on October 6, 2014 (R x 1). Dr. Verma opined that the Petitioner suffered from left shoulder impingement with subacromial bursitis, and further opined that condition was causally related to the work activities based on the nature of the work performed and review of the Petitioner's job description. He further agreed with the recommended surgery (R x 1).

In an addendum letter of November 5, 2014, Dr. Verma changed his opinions on causation, but not his opinions on diagnosis and recommendation for surgery (R x 2). The basis for the changes was Dr. Verma documenting that the Petitioner did not work on October 22, 2013 and a history of onset of pain coming from the removal of a book bag (R x 2).

Conclusions of Law

IN SUPPORT OF THE ARBITRATOR'S DECISION ON ISSUES (C), (D) & (F), WHETHER AN ACCIDENT OCCURRED THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE DATE OF ACCIDENT AND WHETHER PETITIONER'S CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE ACCIDENT, THE ARBITRATOR FINDS THE FOLLOWING:

The Petitioner and all Respondent's witnesses agree to the repetitive heavy physical nature of the Petitioner's occupation as a package handler. This was reiterated in the job description contained within Respondent's Section 12 examiner's report. There is no question that the Petitioner's job activities expose him to a risk greater than that of the general public. There is also no dispute that the Petitioner performed these activities beginning at 10:00 p.m. on October 21, 2013 through 3:00 a.m. on October 22, 2013. There is further no dispute that the

Petitioner did not perform any physical activity from the time he left work until the onset of symptoms other than putting a backpack on his shoulders to go to class and putting on and taking off a jacket. Further, all evidence corroborates that the Petitioner did not first experience symptoms until removing his jacket and/or book bag at approximately 4:00 p.m. on October 22, 2013.

In this case, the issues of accident and causal connection are intertwined and based on the medical records and testimony. As the Petitioner did not have the requisite medical foundation to render an opinion on causation, the Arbitrator is not persuaded by the allegations that the Petitioner did not believe the injuries were work-related.

The Petitioner's treating orthopedic surgeon, Dr. Bilko, provided testimony on this issue (P x 6). Dr. Bilko testified that the work described is the type of repetitive activity that would either cause a tear of the labrum or rotator cuff, the suspected pathology (P x 6, p.17). When asked about whether the delay in symptoms changed his opinions, Dr. Bilko explained that it did not. He elaborated by testifying that it is not uncommon for patients to have an injury, and if they remain active, the ligaments, tendons, muscles and cartilage stay relatively warm and do not bother the patients (P x 6, p.18). After a period of inactivity when the tissues cool and stiffen, the patients then notice the pain when they start activity again (P x 6, p.18).

The chronology presented in this case is consistent with that which Dr. Bilko described. Namely, the Petitioner finished his heavy repetitive work and then went home to sleep, thus the period of inactivity. He then took a bus to class and sat in class. However, when he reached his arm overhead upon returning home to remove the bag and jacket, he felt pain in his left shoulder.

In concluding that the Petitioner sustained accidental injuries on October 21, 2013, the start of the Petitioner's last shift before the symptoms, the Arbitrator is persuaded by the credible

testimony of Dr. Bilko. The Arbitrator finds it more plausible that the heavy repetitive nature of the Petitioner's work activity is the more likely cause of his symptoms as opposed to the innocuous taking on and off of a jacket and/or backpack.

In reaching this conclusion, the Arbitrator is not persuaded by the addendum report authored by Dr. Verma which reversed his previous opinions. Namely, the facts by which Dr. Verma relies upon in his second report are inaccurate. Dr. Verma notes that the Petitioner did not work on October 22, 2013. However, all witnesses agree that the Petitioner continued working until 3:00 a.m. on October 22, 2013.

Further, Dr. Verma testified that the Petitioner carried a backpack for a "full day". On the contrary, the Petitioner had a backpack with straps over both shoulders for a period of time while waiting for the bus, walking from the bus to class and back from class to the bus. It is presumed that the Petitioner did not have his backpack on during the four hours he spent on the bus nor the two hours he was in class. Therefore, contrary to Dr. Verma's assertions, the Petitioner actually spent most of the day after leaving work without his backpack on his shoulders.

Lastly, Dr. Verma states that there is a "significant discrepancy" in the history of injury he was originally provided versus what he was provided for his addendum report. This is also incorrect. At no point in the history section of Dr. Verma's October 6, 2014 report does it state that the Petitioner experienced pain while working. The Petitioner, as he has consistently relayed to all practitioners, told Dr. Verma that the onset of pain was on October 22, 2013. Dr. Verma also reviewed the records of AMCI from July 2, 2014. Those records clearly document that the Petitioner performed repetitive loading of boxes throughout his shift and then felt pain in his left shoulder the "next day" which worsened over the next two days. Accordingly, Dr. Verma had

the accurate history all along and apparently only changed his opinions after further communication from Respondent.

The Arbitrator finds it reasonable that the heavy repetitive nature of the Petitioner's work activities caused the underlying pathology and resultant symptoms. Dr. Bilko's description of why the symptoms did not present themselves until after a period of inactivity (ie. sleep) and upon later use is certainly reasonable. Based on the foregoing, the Arbitrator finds that the Petitioner sustained injuries on October 21, 2013 which arose out of and occurred in the course of his employment by the Respondent.

IN SUPPORT OF THE ARBITRATOR'S DECISION ON ISSUE (K), WHETHER PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS THE FOLLOWING:

Both Dr. Bilko and Dr. Verma agree that the Petitioner is in need of a diagnostic arthroscopy after having failed physical therapy, cortisone injections and anti-inflammatory medications. The only dispute was as to liability. Based on the Arbitrator's findings pertaining to accident and causation, the Arbitrator orders the Respondent to authorize and pay for the prescribed left shoulder diagnostic arthroscopy as such treatment is reasonable, necessary and causally related to the subject accident.

IN SUPPORT OF THE ARBITRATOR'S DECISION ON ISSUE (L), THE PERIOD OF TEMPORARY TOTAL DISABILITY BENEFITS, THE ARBITRATOR FINDS THE FOLLOWING:

The Petitioner claims a period of temporary total disability from October 24, 2013 through the day of the 19(b) hearing, May 1, 2013, a period spanning 79-2/7 weeks. This period of disability was corroborated by the medical records and Petitioner's testimony wherein he was

authorized off of work completely or provided work restrictions pending additional medical care that Respondent was unable to accommodate. The Respondent did not dispute this fact. The only dispute as to temporary total disability benefits was as it relates to accident and causation. Based on the Arbitrator's foregoing findings on accident and causation, the Arbitrator finds that the Petitioner was temporarily and totally disabled from October 24, 2013, the date of his first medical care, through May 1, 2015, the date of the 19(b) hearing.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARY ANNE HIGGINS,

Petitioner,

16IWCC0374

vs.

NO: 11 WC 31456

MATTESON ELEMNTARY SCHOOL DISTRICT 159,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses both current and prospective, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner did sustain her burden of proving the work accident caused her current condition of ill being of both her left knee and lumbar spine, and awards benefits accordingly.

Findings of Fact and Conclusions of Law

1. Petitioner testified on February 16, 2011 she worked for Respondent as a special education resource teacher and had additional responsibilities. On that date she slipped on ice in the parking lot, fell and hurt her left knee. She tried to get up and slipped a second time and fell on her tailbone. She was taken to an emergency department by ambulance where x-rays of her knee and back were taken and medication prescribed. She was not admitted and sent home. Prior to that date she had no injuries to her back or knees. The parties stipulated that Petitioner sustained a compensable accident.

2. Petitioner went to her general practitioner at Well Partners Group and was referred to specialists. She saw Dr. Mehl for her knee as soon as she was able. He performed surgery on her knee on August 12, 2011. He then administered several injections. She then began treating with Dr. Hurley for her back. He performed fusion surgery in October of 2012. The surgery did not resolve her back pain. He performed a second back surgery in May 2014.

3. Petitioner testified that she went to the only Section 12 medical examination Respondent requested. She saw Dr. Suchy for a total of about 15 minutes. He checked her knee but not her back. Respondent did not send her to any examination for her back.

4. Petitioner returned to work for three months beginning on August 18, 2013. She was again taken off work on November 16, 2013 and remained off work since because of her work injury.

5. Petitioner testified she continues to experience knee and back pain and has since the accident. She currently has 8/10 pain every day; "it's excruciating." She goes to the grocery store when she needs to and has to lean on the cart when she does. She has to constantly change her position from sitting, standing, and lying down. She can only do other things when on pain medication. Prior to the injury she danced and socialized. She can no longer engage in such activities, but wished she could. Her doctors have indicated she needed prospective treatment for both her knee and back. Dr. Mehl indicated eventually she will need a knee arthoplasty and Dr. Hurley suggested a pain clinic.

6. On cross examination, Petitioner testified she began working for Respondent in August of 1995. She fell once at work on a field trip and injured her wrist. She filled out an accident report. She also slipped on ice on a previous occasion and filled out a report, but did not sustain any injuries.

7. After the instant accident, Petitioner continued to work through the school year because she "had no idea" what she "had done." She was in physical therapy at the time. She testified she continues to treat with Dr. Mehl for her knee, but there are no scheduled appointments and he released her to full duty regarding her knee. Her current restrictions only relate to her back.

8. Petitioner stated that she does have a future scheduled appointment with Dr. Hurley. She is unable to work because it involves walking between classrooms, bending over to teach children at their desks, and it would not be appropriate to take pain medication while at school.

9. Petitioner also testified she did not recall having any previous cervical issues. She did not remember treating at Well Group Partners for low back pain in September of 2006 or that at that time she reported low back pain for nine months. Petitioner was referring to her back when she testified to 8/10 pain. She currently had about 6/10 knee pain. Dr. Mehl has not scheduled knee replacement because he would not bill her group insurance.

10. Petitioner stated she uses a cane because of both her knee and back. Besides restricting Petitioner from work activities, Dr. Hurley has restricted Petitioner from babysitting her grandson. Petitioner has not had a functional capacity evaluation. No treating doctor has indicated she could return to work in any job. She has not conducted any job search. Petitioner worked as a teacher since 1970.

11. On redirect examination, Petitioner testified she never missed any time from work for any previous injuries to her neck, low back, or knee.

12. The medical records include treatment notes from prior to the instant injury. On December 10, 2004, Petitioner complained of neck and back pain, which was characterized as musculoskeletal. She was referred to physical therapy. On September 7, 2006, Petitioner presented for normal follow for thyroid condition and complained of recurrent left-sided low back pain which radiated down the left leg for nine months. The diagnosis was recurrent sciatica in the left leg. On July 25, 2007, a cervical x-ray showed spondylitic changes at multiple levels and bilateral foraminal stenosis at C3-4. On August 7, 2007, a cervical MRI showed a broad-based left paracentral disc protrusion at C6-7 causing mild central canal stenosis and mild degenerative disc disease with posterior osteophytes and multiple levels causing mild central canal stenosis at C7-T1. On December 21, 2009, Dr. Hurley recommended cervical spine surgery at C5-6 and C6-7, but apparently no cervical surgery was performed.

13. Regarding the instant injury, on February 16, 2011 Petitioner appeared at an emergency department by ambulance complaining of left knee and back pain after falling on ice. She was able to walk after the event. X-rays were ordered. X-rays of the knee appeared normal except for degenerative changes in the patellofemoral joint with no effusion. Similarly, x-rays of the lumbar spine appeared normal except for multilevel degenerative disc disease from L4-S1.

14. On March 23, 2011, Petitioner presented to Dr. Mehl on referral from her general practitioner for evaluation of her left knee. She continued to have pain and problems since she fell at work on February 16, 2011. After examination, Dr. Mehl diagnosed mild degenerative joint disease with acute work related injury with probable medial meniscus tear. Dr. Mehl ordered an MRI and allowed Petitioner to continue working with a brace.

15. After six physical therapy sessions Petitioner complained of increased pain with weightbearing. At rest she got some relief and has only 3/10 pain. The therapist noted that Petitioner was progressing well but further testing may be appropriate to rule out meniscus involvement. Dr. Mehl ordered an MRI.

16. On June 20, 2011, Dr. Mehl noted that an MRI showed a high grade chondromalacia of the patellofemoral joint but showed no meniscal tears. On August 12, 2011, Dr. Mehl performed left knee arthroscopy, partial medical meniscectomy, and diffuse chondroplasty for persistent left knee chondromalacia and pain with medical meniscus tear.

17. On September 12, 2011, Dr. Mehl noted that Petitioner reported limited recovery after surgery where a lot of chondroplasty was performed. She also had a work injury to her back, which in combination with her knee injury made it impossible for her to continue working as a teacher. About two months later, Dr. Mehl administered a cortisone injection for persistent pain.

18. On December 12, 2011, Dr. Mehl indicated that the cortisone injection "helped a lot" but she still had some popping and cracking. She was off work as a teacher due to her back. He declared her at maximum medical improvement after the arthroscopy, refilled Vicodin, and released her to work as a teacher with regard to the knee injury and from treatment.

19. On January 30, 2012, Petitioner returned to Dr. Mehl and he administered a Synvisc injection. Two months later, Dr. Mehl noted the Synvisc injection provided 60% relief. He also indicated the surgery in which she had "grade III and grade IV chondromalacia in the patellofemoral joint a significant amount of which was post-traumatic in nature." He thought she would need additional injection treatment in the future.

20. On December 31, 2012, Dr. Mehl indicated Petitioner was due for another Synvisc injection in August, but it was denied. Petitioner reported constant pain which was currently 4/10 with burning and feeling of giving out. Dr. Mehl diagnosed "status post left knee arthroscopy – work injury" and "work related severe posttraumatic chondromalacia pain." He administered another Synvisc injection and then another on July 17, 2013, under Petitioner's group health insurance.

21. On February 26, 2014, Dr. Mehl noted that Petitioner continued to have further degeneration of her cartilage as a result of her work injury. She also had five degree varus deformity and crepitus. The previous injection provided relief for two to three months. Dr. Mehl opined that Petitioner would most likely need a knee replacement. He attributed that need to an exacerbation of her preexisting condition by her traumatic work injury. He administered another Synvisc injection and administered another on August 29, 2014.

22. Regarding Petitioner's back condition, she presented to Dr. Hurley on April 21, 2011 for evaluation of low and mid back pain after she slipped on ice and fell in February 2011. The pain had been gradually worsening. He prescribed Hydrocodone and an MRI. The MRI showed diffuse disc bulge at L1-2 with superimposed spinal cord stenosis, grade I spondylolisthesis at L4-5 combining with facet arthropathy and ligamentum flavum thickening causing some spinal cord stenosis, and narrowing of the neural foramen and lateral recesses bilaterally with encroachment on the exiting L4 nerve root.

23. In June of 2012, two lumbar epidural steroid injections were administered.

24. A CT taken on August 26, 2011 was compared to the April 2011 MRI. It showed overall stability with grade I spondylolisthesis secondary to facet degeneration and mild stenosis.

25. On October 11, 2012, Dr. Hurley noted that Petitioner had suffered a fall on ice in February of 2011 which aggravated her preexisting degenerative disc disease. An MRI showed degenerative disc disease at L4-5 and L5-S1 with grade I spondylotic changes with neuroforaminal stenosis. Petitioner failed conservative treatment and presented for surgery. Dr. Hurley performed L4-5 posterior interbody fusion with instrumentation and autograft and bilateral L4-5 screw fixation and bone arthrodesis.

26. Petitioner did not progress well after surgery, On August 9, 2013, she reported to Dr. Hurley that she fell the previous day when her knee buckled and was complaining of low back pain radiating into her legs bilaterally. Dr. Hurley noted that she appeared "very uncomfortable." He did not think she could return to work due to persistent back and knee issues.

27. On October 9, 2013, Petitioner returned to Dr. Hurley and indicated she was told to return to work by her lawyer after a Section 12 examination. However, she had to call off work because her low back pain got worse. She now also complained of pain in the right leg as well as left leg pain. Dr. Hurley did not agree with her returning to work and indicated she needed a new MRI.

28. On December 30, 2013, Petitioner reported her condition worsened when she had returned to work. Dr. Hurley indicated the MRI showed new L3-4 lateral recess stenosis and what he thought was slightly worse stenosis at L5-S1, though the radiologist interpreted the MRI to be similar to the previous study. Dr. Hurley believed Petitioner fulfilled the criteria for failed back surgery syndrome, but he did not believe additional surgery would likely alleviate the problem. Her worsening condition might all be due to her being forced to return to work for three months. They discussed going back to the pain clinic.

29. On March 28, 2014, Dr. Hurley noted Petitioner was still not doing well. Her right leg pain was now actually worse than her chronic left leg pain. She went to another pain clinic and was taking Lyrica, which was not effective and stopped the previous day. They were considering a trial of injections. Petitioner also informed him that she was "told that due to her fall her knee has deteriorated" and she will need a knee replacement. Dr. Hurley concerned that her new right leg pain likely showed L5 nerve involvement. He recommended surgery and Petitioner agreed.

30. On May 12, 2014, Dr. Hurley performed L3-4 posterior interbody fusion with instrumentation and autograft, L5-S1 laminectomy and complete facetectomy and foraminotomy, and bilateral L3-4 screw fixation and bone arthrodesis for adjacent degeneration L3-4 and L5-S1 with L3-4 herniated disc, facet arthropathy, spinal stenosis, and L5-S1 facet arthropathy and neural foraminal stenosis.

31. On June 27, 2014, Dr. Hurley noted that Petitioner was doing better with reduced back and right leg pain. However, the left leg pain persisted. X-rays showed good alignment and fusion. Dr. Hurley thought she could start physical therapy.

32. On September 25, 2014, Petitioner returned to Dr. Hurley and reported that she still had low back and left leg pain. She had not made much progress in physical therapy. Dr. Hurley was disappointed that the surgery did not help Petitioner's left leg pain. They again discussed going to a pain clinic. He noted that the FDA had changed the rules about prescribing Norco and she would have to pick up written prescriptions. He encouraged her to "use it less and less."

33. Dr. Suchy was deposed by Respondent on June 25, 2013. He testified he is a board certified orthopedic surgeon and independent medical examiner. He examined Petitioner on May 27, 2011 and reviewed medical records at Respondent's request. That was the only time he examined her. On his examination he noted no atrophy or effusion in her leg. His examination of her back appears to have been normal except for pain with hyperextension and subjective complaints of pain generally.

34. An MRI of the knee showed high-grade chondromalacia of the patellofemoral joint with mild to moderate arthritic changes. An MRI of the lumbar spine showed diffuse disc bulging at multiple levels with spinal stenosis and spondylolisthesis of L4 on L5 with facet arthroplasty but no acute abnormality.

35. Dr. Suchy diagnosed left knee contusion with exacerbation of pre-existing chondromalacia patella, and lumbar strain with exacerbation of pre-existing degenerative disc disease and spondylolisthesis. Dr. Suchy concluded the chondromalacia was pre-existing because the knee MRI showed an advanced condition and there was no effusion. Similarly the lumbar MRI showed a long-standing degenerative process of the facet joints and bulging discs and spondylolisthesis would be acute only from a severe trauma.

36. In his Section 12 medical examination report, Dr. Suchy recommended arthroscopic evaluation of the knee with chondroplasty of the patella. She should be able to return to work as a special education teacher in two to three weeks and would be at maximum medical improvement in three to four months. He only recommended six to eight weeks of physical therapy for Petitioner's lumbar condition at which time she should have returned to her pre-exacerbation condition. He did not believe that back surgery was indicated at that time because he found no neurological deficits. If surgery was eventually needed it would not be the result of her February 16, 2011 injury.

37. Dr. Suchy testified that subsequent to his initial report, he received additional medical records and on November 5, 2011 he reached the conclusion that Petitioner had reached maximum medical improvement with regard to the February 16, 2011 aggravation of the pre-existing condition of her back. At that time he offered no opinion regarding Petitioner's knee condition.

38. On cross examination, Dr. Suchy testified he found no atrophy in Petitioner's left leg. He reiterated that he initially found a causal relationship between the work accident and an exacerbation of Petitioner's pre-existing knee and lumbar conditions. A simple slip and fall on buttocks can aggravate anterolisthesis but cannot cause it. He had no documentation indicating that the condition was present prior to the accident.

39. On redirect, Dr. Suchy testified that after reviewing Dr. Hurley's records, his opinion did not change that any need for fusion surgery was caused by the natural progression of Petitioner's degenerative disc disease and not the February 16, 2011 injury.

40. Dr. Hurley was deposed by Petitioner on November 1, 2013. He testified that he is board certified in neurological surgery. He first saw Petitioner on October 9, 2007 when he saw her for a cervical herniated disc for which he treated conservatively. He last saw Petitioner regarding her cervical spine in December of 2009. At that time she had never complained of low back pain.

41. Dr. Hurley saw Petitioner again on April 21, 2011, at which time she reported slipping and falling on ice in February and had back and left knee pain since. He ordered an MRI for her back. It showed several degenerated discs and evidence of grade I spondylolisthesis at L4-5 with moderate neuroforaminal stenosis. That condition is a common cause for low back pain.

42. Dr. Hurley opined that "certainly with her history" "the fall somehow caused the onset of back pain." He disagreed with the opinion of Dr. Suchy that the only way such a condition could be aggravated was from a fall from about 20'. He thought Dr. Suchy might have been referring to traumatic spondylolisthesis from a fracture. Low impact injuries can aggravate spondylolisthesis from facet disease.

43. Dr. Hurley also testified that he agreed that about 85% of back pain is related to muscle injury. However, he disagreed with the assessment of Dr. Suchy that Petitioner's condition was temporary in nature because her symptoms lasted longer than a simple exacerbation and "more importantly, she had a structural issue to her spine."

44. Initially, Dr. Hurley prescribed physical therapy and epidural steroid injections. However, that treatment did not help and Petitioner continued to have back pain radiating into her buttocks and legs. Therefore, he performed L4-5 interbody fusion surgery. He kept her off work from September of 2011 "until very recently when she was required to return to work."

45. Dr. Hurley had her off work exclusively due to her back injury. He opined that Petitioner was off work from September 2011 to the beginning of the 2013 school year "because of her persistent and chronic pain" caused by her February 16, 2011 injury. Petitioner was not at maximum medical improvement. He normally follows up with fusion patients for two years to ensure that the bone graph was in proper place and solidifies. Because she still had pain a year past surgery he anticipated referral to a pain specialist.

46. On cross examination, Dr. Hurley testified the first time Petitioner complained to him about low back pain was on April 21, 2011. He did not see any records of her treating with another doctor for her back but he thought she had a general practitioner. He agreed that Petitioner's spondylolisthesis existed prior to her accident but the accident aggravated the condition.

47. Dr. Hurley also testified that Petitioner reported no previous back pain prior to the accident. Dr. Hurley did not formally take Petitioner off work until September of 2011 because that was when she asked him. He was under the impression that she was off work due to her knee condition. The CT was taken on August 26, 2011 to rule out a fracture. It showed the spondylolisthesis but did not show acute changes. He agreed that spondylolisthesis changes occur over time.

48. Dr. Mehl was deposed by Petitioner on June 2, 2014. He testified he is board certified in orthopedic surgery. He practices general orthopedics and does "a lot of surgery on knees, hips and shoulders." He does minor surgery on extremities but does not treat the spine.

49. Dr. Mehl first saw Petitioner on March 23, 2011. X-rays taken on the date of the accident showed only mild degenerative changes. She continued to work but continued to have knee pain. On examination, Dr. Mehl found reduced range of motion, tenderness, and crepitus. She had a positive "McMurray's stressing the medical meniscus, but no knee instability." Petitioner did not indicate she had any problem with her left knee prior to her accident. He diagnosed pre-existing mild degenerative joint disease and a medial meniscus tear from the fall at work. He provided a knee brace, told her to continue the Vicodin as needed, and ordered an MRI. The MRI was denied; "they wanted physical therapy before anything else." In his practice Dr. Mehl would want an MRI before prescribing PT to avoid risk of additional injury to a possible torn cartilage.

50. Petitioner had physical therapy but reported "absolutely no improvement in her pain." She also indicated that the therapist thought she had a meniscus tear, which was Dr. Mehl's initial impression as well. Thereafter, an MRI was approved.

51. The MRI was interpreted as showing a high grade chondromalacia of the patellofemoral joint with no definite meniscal tear. He performed arthroscopic surgery on August 12, 2011, in which he found there was indeed a torn meniscus, which he repaired, as well as performing a diffuse chondroplasty. The meniscal surgery was "substantial" and he had to remove "a moderate amount of the torn medial meniscus."

52. Petitioner progressed slowly after surgery. She continued to have pain, reduced range of motion, and weakness. He administered cortisone injections. The cortisone injections helped with the pain but did not appear to improve her strength. Dr. Mehl kept her off work until he released her to full duty with regard to her knee on December 12, 2011.

53. Dr. Mehl had absolutely no opinion on whether Petitioner could resume working with regard to her back condition. Petitioner mentioned back pain to him but he never examined her back. He administered a Synvisc injection in January of 2012 after the cortisone injection was wearing off. He wanted authorization for another Synvisc injection all further injections were denied. X-rays showed a progression of her degenerative joint disease so he administered another Synvisc injection under her group health insurance.

54. Dr. Mehl opined that Petitioner had pre-existing degenerative joint disease which was exacerbated by the injury. In addition, the injury caused a medial meniscus tear and traumatic injury to anterior cartilage. All the treatment that he provided was necessitated by the work injury. He last saw Petitioner on February 26, 2014. At that time she had "severe degenerative disease which had significantly progressed since the first x-ray comparison taken at the time of her injury." That degeneration was posttraumatic and her ongoing problem was related to her injury of February 16, 2011.

55. On cross examination, Dr. Mehl testified chondromalacia can be either degenerative or traumatic in nature or a combination of both. He thought Petitioner had moderate pre-existing chondromalacia in all compartments prior to the accident. He disagreed with Dr. Suchy's assessment that Petitioner suffered a left knee contusion with an exacerbation of chondromalacia patella; she had traumatic damage to the articular cartilage and medial meniscal tear. Her back condition affected her functionality but did not contribute to her knee pain itself.

56. Dr. Mehl placed her at maximum medical improvement on December 12, 2011, except for occasional injections, and released to full-duty work. He did not impose any restrictions because of her knee since and would not currently place any now. The five degree varus deformity he noted on February 26, 2014 progressed too quickly to be degenerative. At his last visit he recommended another Synvisc injection but not additional surgery.

57. On redirect examination, Dr. Mehl testified he did not recommend total knee replacement, but if the Synvisc injection did not relief her arthritic pain such surgery may be indicated. If the surgery was performed she would be off work for about three months.

58. Dr. Suchy issued an addendum Section 12 medical report on May 5, 2014, after his deposition testimony. He had reviewed additional medical records and answered interrogatories. He opined that treatment rendered to Petitioner for her back after November 5, 2011 was not related to her February 26, 2011 work injury. The October 11, 2012 fusion surgery was medically indicated but the need for such surgery was not related to her work injury. Similarly, treatment of the left knee since November 5, 2011 was medically indicated but not related to the work accident. He agreed that she needed permanent restrictions after the diagnosis of failed back syndrome, which would include no lifting over 10-15 lbs with no excessive standing, walking, bending, or squatting. However, those restrictions were necessitated by her underlying condition and not her work injuries.

In finding Petitioner had not proved causation of her current conditions of ill-being of her knee and lumbar spine, the Arbitrator noted that Petitioner was able to work the rest of the school year and there was no knee effusion found in the emergency department. She also stressed that the tests taken within temporal proximity of the accident all appeared to be normal, her initial injuries were relatively benign, and that it was "undisputed that Petitioner had significant pre-existing degenerative issues in both her left knee and back."

16IWCC0374

The Commission reverses the Decision of the Arbitrator and finds that Petitioner did sustain her burden of proving the stipulated work-related injury of February 16, 2011 caused the conditions of ill being of both her left knee and lumbar spine, respectively. The Arbitrator is correct that Petitioner did have pre-existing conditions of ill being of both her left knee and lumbar spine, according to both her current treating doctors, Dr. Hurley and Dr. Mehl, as well as Respondent's Section 12 medical examiner, Dr. Suchy. However, there is no indication that these conditions were symptomatic prior to the accident. There is absolutely no evidence of any previous complaints or treatment of her knee whatsoever. While there are mentions of low back complaints twice, once in 2004 and once in 2006, there is no indication that she received any treatment for her lumbar spine at that time, or any other time, prior to the current accident.

In addition, the Commission finds the opinions of Petitioner's treating doctors more persuasive than that of Respondent's Section 12 medical examiner. Dr. Mehl and Dr. Hurley were able to monitor condition through the years of treatment and to note the persistence of her symptoms. On the other hand, Dr. Suchy only examined Petitioner once, within three and a half months of the accident, and therefore was not able to observe the extent and persistence of her symptoms. Regarding Petitioner's knee condition, Respondent's Section 12 medical examiner, Dr. Suchy, actually recommended arthroscopic evaluation of the knee with chondroplasty of the patella. Then when Dr. Mehl actually performed the arthroscopic evaluation, he noted that through surgery he realized that the meniscal surgery was "substantial" which was more pathology than originally anticipated and more pathology than seen in the MRI. Therefore, he had to remove "a moderate amount of the torn medial meniscus."

The Commission also finds the causation opinion of Dr. Mehl more persuasive that that of Dr. Suchy. Dr. Mehl opined that although Petitioner had moderate pre-existing chondromalacia in all compartments prior to the accident, she also she had traumatic damage to the articular cartilage and medial meniscal tear. He also testified that it was the aggravation from the accident which necessitated all of his treatment of her knee. Dr. Suchy's opinion that she suffered only a contusion is not persuasive because Dr. Mehl did not explain why such a simple contusion, causing only a temporary exacerbation, would result in persistent and ongoing symptoms for more than five months leading up to surgery.

Similarly, the Commission finds the causation opinion of Dr. Hurley more persuasive than that of Dr. Suchy. Dr. Hurley's opinion that the work injury caused an aggravation of Petitioner's pre-existing back condition necessitating treatment is supported by the medical records which are completely devoid of any previous treatment for her lumbar spine. On the other hand, once again Dr. Suchy did not adequately explain how a temporary exacerbation of Petitioner's pre-existing lumbar condition would result in many months of continuous symptoms without her ever returning to her pre-exacerbation status. Therefore, based on the sequence of events evidenced by the onset of symptoms after the work-related accident, the lack of evidence that Petitioner had any treatment for her knee or back prior to the work injury, the credible testimony of Petitioner, and the persuasive opinions of her treating doctors, Dr. Hurley and Dr. Mehl, the Commission concludes that Petitioner sustained her burden of proving the conditions of ill being of her left knee and lumbar spine were caused by the work accident of February 16, 2011.

The Arbitrator awarded Petitioner temporary total disability benefits of 17&4/7 weeks from August 12, 2011 through December 12, 2011, terminating temporary total disability on the date that Dr. Mehl initially found her at maximum medical improvement and released her to full duty relating to her knee condition. Because the Commission finds that Petitioner's work-related conditions of ill being extended beyond December 12, 2011, we modify the award of temporary total disability benefits.

The Commission awards temporary total disability benefits from August 12, 2011, the date Dr. Mehl performed knee surgery and took her off work, to August 13, 2013, when she returned to work on the advice of her lawyer after Dr. Suchy's Section 12 medical examination report. Thereafter, the Commission reinstates temporary total disability benefits commencing on November 15, 2013, the date on which she testified she could no longer work. That inability was corroborated by Dr. Hurley's opinion that she should not have been returned to work in August.

The Commission finds that an appropriate date to terminate temporary total disability benefits to be September 25, 2014. That was the last treatment note in the record representing the last time Petitioner was seen by Dr. Hurley. The Commission concludes that Petitioner's conditions largely stabilized as of September 25, 2014. Accordingly, the Commission awards temporary total disability benefits of 149&2/7 weeks.

The Commission finds all the medical treatment provided to Petitioner to date were reasonable and necessary to treat her conditions of ill being of her left knee and lumbar spine. Therefore, the Commission awards all the medical expenses Petitioner submitted into evidence, including direct reimbursement to Petitioner for all out-of-pocket expenses.

Regarding the issue of prospective medical treatment, the Commission notes that while Petitioner preserved the issue of prospective treatment in her Petition for Review, she does not request any specific prospective treatment in her brief. It is certainly possible that Petitioner may seek treatment in the future, which could include Synvisc injections or arthroplasty for her knee, *per* Dr. Mehl, and/or pain management for her back, *per* Dr. Hurley. If Petitioner does elect to have such treatment she could return to the Commission through a petition under Section 8(a) of the Act to seek an award of these and associated expenses.

Although the Arbitrator found Petitioner did not prove that her current conditions of ill being of her left knee and lumbar spine were not caused by her work-related accident, she nevertheless awarded her a total of 91.25 weeks of permanent partial disability benefits representing the loss of 25% of the left leg and 7.5% loss of the person as a whole for her lumbar condition, respectively.

Petitioner seeks a finding by the Commission that she is permanently and totally disabled. The Commission does not find that Petitioner is permanently and totally disabled. No doctor has opined that Petitioner is permanently and totally disabled from employment, Petitioner did not have a functional capability evaluation, she did not conduct a job search, and she did not request vocational rehabilitation.

16IWCC0374

In looking at the entire record before us, the Commission concludes that an appropriate permanent partial disability award is loss of 30% of the left leg, due to her knee condition, and loss of 40% of the person as a whole for her lumbar condition. In arriving at this award, the Commission notes that Petitioner was 61 years of age at the time of the accident and turned 67 years of age on April 16, 2016. Therefore, Petitioner has not proven a substantial loss of future earning potential. In addition, as noted above regarding prospective medical expenses, Petitioner may return to the Commission and seek additional benefits in a petition under Sections 8(a)and 19(h) of the Act if she suffers a change in her condition or needs additional medical care.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator issued May 5, 2015 is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,129.41 per week for a period of 149&2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 264.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of the use of 40% of the person as a whole and loss of 30% of her left leg, respectively.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses submitted into evidence, including direct reimbursement for out-of-pocket expenses under §8(a) of the Act pursuant to the applicable medical fee schedule. Respondent is entitled to credit for any payments it paid on the awarded bills either directly under the Workers' Compensation Act or through a group policy that qualifies under Section 8(j) of the Act

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

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 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: JUN 6 - 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-5/25/16
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mamta M. Dixit,
Petitioner,

vs.

NO: 12 WC 12483

16IWCC0375

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 30, 2015, is hereby affirmed and adopted.

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

16IWCC0375

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: JUN 7 - 2016

Joshua D. Luskin

Ruth W. White

Charles J. DeVriendt

o-05/25/16
jdl/wj
68

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

DIXIT, MAMTA M
Employee/Petitioner

Case# 12WC012483

TCF NATIONAL BANK TCF FINANCIAL CORPORATION
Employer/Respondent

16IWCC0375

On 6/30/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% 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:

1876 PAUL W GRAUER & ASSOC
CZAPLA, EDWARD A
1300 E WOODFIELD RD SUITE 203
SCHAUMBURG, IL 60173

1109 GAROFALO SCHREIBER HART ETAL
DAVID HANSON
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Mamta M. Dixit
Employee/Petitioner

v.

TCF National Bank, TCF Financial Corporation
Employer/Respondent

Case # 12 WC 12483

Consolidated cases: n/a

16IWCC0375

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **April 30, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 29, 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 $**60,684.00**; the average weekly wage was $**1,167.00**.

On the date of accident, Petitioner was **47** 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 $**13,950.64** for TTD, $**0** for TPD, $**0** for maintenance, and $**33,172.12** for other benefits, for a total credit of $**47,122.76.**

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services incurred through 6/5/2013, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Partial Disability

Respondent shall pay Petitioner temporary partial disability benefits of $778.00/week for 5.52 weeks, commencing 12/29/11 through 2/5/12, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $3,216.40 for the period commencing February 6, 2012 through March 25, 2012 as provided by Section 8(a) of the Act.

Credits

Respondent shall be given credit for $ 29,343.38 for medical benefits paid under Section 8(a) of the Act.

Respondent shall be given a credit of $**13,950.64** for TTD benefits paid under Section 8 of the Act.

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

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

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

Deborah L. Simpson
Signature of Arbitrator

June 26, 2015
Date

ICArbDec19(b)

JUN 30 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MAMTA M. DIXIT, Petitioner, vs. TCF NATIONAL BANK, TCF FINANCIAL CORPORATION, AND THE HARTFORD FINANCIAL SERVICES GROUP, INC., Respondent.	)	No. 12 WC 12483 16IWCC0375

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on December 29, 2011, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that on that date the Petitioner sustained accidental injuries that arouse out of and in the course of the employment and that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $60,684.00, and that her average weekly wage was $1,167.00.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) Is the Respondent liable for the unpaid medical bills contained in Petitioner's Exhibits numbered 14 through 33; (3) Is Petitioner entitled to TTD from December 30, 2011 through February 5, 2012, and April 17, 2014, through April 30, 2015; and (4) Is the Petitioner entitled to prospective medical treatment.

Prior to the start of the hearing, it was determined that notice had not been provided to The Hartford Financial Services Group, Incorporated, and a named Respondent. The Petitioner made an oral motion to strike the Hartford Financial Services Group, Incorporated as a Respondent, the motion was granted. There was also a discussion regarding the question of short term and long term disability benefits. Both parties agreed that Ms. Dixit had received payment but neither party knew how much money was paid in short term or long term disability benefits. The parties agreed to find out how much was paid and to address the amount in their proposed decisions.

After reviewing the records of payment of short and long term disability, the parties have stipulated that the respondent paid $13,960.64 in TTD benefits, $33,172.12 in short and long term disability benefits and $29,343.38 in medical bills.

STATEMENT OF FACTS

Petitioner was employed by the Respondent as an assistant Vice-President for loans. She worked for Respondent for 19 years; more than ten of those years were spent in the loan department. (Tr. 21). For the past two years, Petitioner was in the job of collections, which required her to travel to the homes of customers to collect money on the mortgages that they had defaulted on. (Tr. 22) On the evening of December 29, 2011, Petitioner was traveling to a customer's house to collect on a defaulted loan when she was involved in an automobile collision. (Tr. 21-22).

Petitioner had left the Palatine office and was driving to a customer's house when she was struck head on by a hit and run motorist traveling 30 miles per hour. (Tr.22-24). Petitioner testified that she "was hit very hard" and lost consciousness "for a few minutes". (Tr. 25). Petitioner's head, neck, left shoulder, left leg and back struck the inside of her vehicle. (Tr. 25). Petitioner testified that the person who struck her vehicle was travelling at 30 miles per hour. (Tr. 24)

Petitioner was taken from the scene by ambulance and transported to the emergency room at Northwest Community Hospital. (Tr. 26). Petitioner initially complained of neck pain and headaches, low back pain and left leg pain. (Px. 1). CT scan of the brain, neck, chest and abdomen/pelvis were unremarkable. (Px. 1). Petitioner was diagnosed with a head injury, cervical and lumbar sprain and prescribed Norco. (Px. 1).

Petitioner followed up with her primary care physician, Dr. Jeffrey Eye, on January 3, 2012 complaining of head, neck, left shoulder and back pain. (Px. 2). Petitioner reported chest pains and was transferred to the emergency room at Alexian Brothers Medical Center for further diagnostic study. (Px. 2).

Petitioner complained of headaches, neck and back pain, chest pain and bilateral leg pain. (Px. 2). CT of the head, neck and chest were negative. (Px. 2). Petitioner was prescribed Valium, Toradol, Dilaudid and Zofran and instructed to follow up with Dr. Eye.

Petitioner returned to Dr. Eye on January 10, 2012 complaining of headaches, neck and back pain and left shoulder pain. (Px. 3). Dr. Eye prescribed physical therapy treatment for the neck, low back and left shoulder and referred Petitioner to Dr. Kuhlman, a neurologist, for further medical treatment. (Px. 3).

On January 16, 2012 Petitioner saw Dr. Kuhlman and reported ongoing headaches, neck and back pain and left shoulder pain. Petitioner further reported that over the last two weeks she developed "chronic left hemi cranial headaches involving pressure-like sensation behind her left eye, as well as shooting pain from the base of her skull into her left ear, chronic neck pain at times radiating down her left arm and into her left shoulder and low back pain at times associated with numbness and paresthesia involving her left thigh". (Px. 4)

Neurological examination revealed slightly diminished range of motion and cervical and lumbar paraspinal tenderness. (Px. 4). Dr. Kuhlman's initial diagnosis was: Multi focal pain; Headaches; Cervical sprain; Lumbar sprain; and Post traumatic left occipital neuralgia. (Px. 4)

MRI of the brain and cervical spine were ordered along with a course of physical therapy. (Px. 4). Petitioner was prescribed Lyrica and Zanaflex and referred to Suburban Associates in Ophthalmology for further consultation. (Px. 4).

MRI of the brain completed on January 17, 2012 revealed: 5mm focal area of increased T2 signal in the right, periventricular frontal white matter. (Px. 4)

MRI of the cervical spine performed on January 17, 2012 revealed: C4-C5 mild posterior disc spur complexes; and C5-C6 mild posterior disc spur complexes. (Px. 4)

Dr. Eye referred Petitioner to Dr. Mary Morrell, an orthopedic surgeon, who examined Petitioner on January 17, 2012. Petitioner reported neck and shoulder pain as well as lower back pain with an occasional burning and numbness down the left leg to the foot. (Px. 5). Examination of the cervical spine revealed tenderness over the paraspinal musculature with decreased range of motion. (Px. 5). The left shoulder also revealed minimal tenderness to palpitation and a mild positive impingement test. (Px.5) Examination of the lumbar spine revealed tenderness to palpation and tenderness with range of motion especially with flexion, extension, and rotation. (Px. 5).

Dr. Morrell diagnosed Petitioner with a cervical strain, left shoulder strain and left lumbar radiculopathy and prescribed physical therapy for the neck, left shoulder and back. (Px. 5).

Petitioner was examined for increased pressure in the left eye at Suburban Associates in Ophthalmology on January 24, 2012. (Px. 6).

Petitioner completed a course of physical therapy treatment for the neck, left shoulder and low back at Accelerated Rehabilitation between January 26, 2012 and May 16, 2012. (Px. 7).

Petitioner returned to Dr. Kuhlman on January 30, 2012 complaining of headaches, neck and back pain and aching discomfort in her legs with burning paresthesia in her thighs. (Px. 4). Dr. Kuhlman noted the MRI of the brain demonstrated a few small subcortical increased intensity spots. Dr. Kuhlman increased Petitioner's Lyrica to 50mg 3 times/day, ordered Gabapentin 50mg 3 times/day, and ordered an MRI of the thoracic and lumbar spine along with an EMG/NCV of the lower extremities.

MRI of the thoracic spine performed on January 31, 2012 was unremarkable. However, the MRI of the lumbar spine completed at that time revealed: L2-L3 moderate central and right paracentral disc extrusion with cranial migration along dorsal aspect of L2 by 6mm; L4-L5 mild to moderate diffuse disc bulge with a superimposed small right lateral disc protrusion; Moderate ligamentum flavum hypertrophy and mild to moderate disc bulge at L4-L5 causing mild bilateral neuroforaminal stenosis and mild spinal canal stenosis. (Px. 4).

EMG of the lower extremities completed on February 3, 2012 was normal. (Px. 4). Dr. Kuhlman examined Petitioner on March 1, 2012 and increased her Gabapentin to 600mg 3 times/day. Petitioner was referred to Dr. Broderick for neurosurgical assessment and to Dr. Lipov for pain management. (Px. 4). A functional capacity evaluation was also recommended. (Px. 4).

On March 9, 2012, Petitioner was examined by Dr. Richard Broderick at Surgical Neurology Associates. Petitioner reported pain in her neck, left shoulder, low back and both hips with numbness in her left leg. (Px. 4). Dr. Broderick's diagnosis was cervicalgia secondary to

whiplash type injury from a motor vehicle accident and a herniated disc at L2-L3 without convincing evidence of lumbar radiculopathy. (Px. 4). Dr. Broderick did not recommend surgery for the cervical spine but recommended physical therapy and epidural steroid injections for the lumbar spine. (Px. 4).

Petitioner completed the functional capacity evaluation on March 15, 2012 which revealed she was capable of working at a "sedentary" demand level. (Px. 7). Thereafter, Dr. Kuhlman released Petitioner to return to sedentary work on March 26, 2012. (Px. 4).

On April 3, 2012 Petitioner returned to Dr. Kuhlman complaining of left shoulder and low back pain. Dr. Kuhlman recommended a trial of Skelaxin 800mg 3 times/day and referred Petitioner to Dr. Morrell for her left shoulder and Dr. Lipov for possible injections. (Px. 4).

Dr. Lipov examined Petitioner on May 21, 2102 and noted "lower back-aching and shooting that is constant with radiation down left lower extremity; intermittent numbness/tingling shoulder – pins and needles sensation." (Px. 8). Neurological examination was positive for left hand paresthesia and intermittent numbness/tingling left lower extremity. (Px. 8). Dr. Lipov diagnosed Petitioner with lumbar radiculitis and left shoulder arthralgia. Petitioner received a left lumbar epidural steroid injection and an MRI of the left shoulder was ordered. (Px. 8).

Petitioner returned to Dr. Kuhlman on June 7, 2012 complaining of an increase in headaches, neck, back and left shoulder pain. (Px. 4). Dr. Kuhlman ordered a repeat MRI of the brain and restarted Petitioner on Zanaflex. (Px. 4). Petitioner was again referred to Dr. Morrell for her shoulder pain.

Petitioner received medical treatment at Alexian Brothers Medical Center on June 13, 2012 reporting headaches on the left side of her head, left hand weakness and left and right leg weakness. (Px. 2). CT scan of the brain performed on that date revealed an osteoma obstructing the outflow of the left frontal sinus consistent with the prior study but was otherwise normal. (Px. 4). CT scan of the neck confirmed the osteoma in the left frontal sinus.

MRI of the left shoulder completed on June 26, 2012 revealed signal hyper intensity in the anterior distal supraspinatus tendon in a pattern consistent with tendinosis or a focal tendon strain. (Px. 8).

On July 19, 2012 Petitioner received a second L4-L5 lumbar epidural steroid injection from Dr. Lipov which provided 50% improvement in her low back pain. (Px. 8).

Petitioner returned to Dr. Kuhlman on August 7, 2012 reporting improvement in her low back pain after the epidural injection along with improvements in her headaches which were "occurring only about once a week." (Px. 4). Dr. Kuhlman continued the Gabapentin for Petitioner's back pain and ordered a repeat MRI of the brain which was unchanged from the original MRI of January 17, 2012. (Px. 4).

Petitioner testified that between August 8, 2012 and April 26, 2013, she did not receive any medical treatment. (T.47). On April 26, 2013 Dr. Kuhlman ordered additional physical therapy treatment for Petitioner's ongoing neck, back and left shoulder pain. (Px. 4). Petitioner completed a course of physical therapy at Accelerated Rehabilitation between April 29, 2013 and June 5, 2013 (Px. 7).

Petitioner did not receive or request any medical treatment between June 5, 2013 and November 18, 2013. Then, on November 18, 2013 the Petitioner returned to Dr. Morrell complaining of "pain into

the left side of her neck which radiates down the arm from the shoulder into the fingers." (Px. 5). Petitioner also reported "increasing left buttock pain which radiates into the posterior thigh and will occasionally go down the whole leg". The record for treatment on that date notes that she had increased symptoms over the last month. (Px. 5). Petitioner was diagnosed with left cervical radiculopathy and left lumbar radiculopathy. Dr. Morrell ordered additional physical therapy treatment which Petitioner completed at the Centers for Physical Therapy between November 26, 2013 and April 17, 2014. (Px. 10).

Petitioner continued to experience neck and back pain along with left shoulder pain radiating down the left arm for which she saw Dr. Morrell. (Px. 5). Examination revealed positive impingement sign in the left shoulder for which Petitioner received a cortisone injection on February 27, 2014. (Px. 5). In March 2014, Dr. Morrell ordered an H-wave home electrotherapy system for Petitioner's ongoing neck, back and left shoulder pain. (Px. 5). Petitioner used the electronic stimulation machine daily for 30 minutes at a time for her left shoulder and low back. (Tr. 50).

Petitioner returned to Dr. Morrell on April 17, 2014 reporting 1 week of relief in her left shoulder from the cortisone injection. (Px. 5). Petitioner continued to complain of burning pain radiating from her neck down the left arm along with low back pain radiating into both legs. (Px. 5). Dr. Morrell ordered an MRI of the left shoulder and back and referred Petitioner back to Dr. Lipov for cervical and lumbar epidural steroid injections. (Px. 5). Dr. Morrell also prescribed physical therapy and took the Petitioner off of work. (Px.5).

On April 22, 2014 Dr. Lipov prescribed a Medrol Dosepak for the radiating neck and back pain going down both legs. (Px. 8).

MRI of the left shoulder performed on June 11, 2014 revealed: Mild inferior hypertrophic spurring in the acromioclavicular joint, 2-3mm, slightly indenting the supraspinatus tendon with some narrowing of the subacromial space; and mild inflammatory fluid surrounding the distal supraspinatus tendon with fluid in the subacromial/subdeltoid bursa, representing tendinitis and/or bursitis. (Px. 5)

MRI of the cervical spine performed at the same time revealed: C6-C7 2-3mm posterior disc bulge noted to indent the thecal sac, without spinal stenosis or significant neuroforaminal narrowing. (Px. 5)

On June 12, 2014 Dr. Morrell noted increasing numbness and tingling in the left arm into the thumb and index finger and ordered an EMG/NCS of the left upper extremity.

The EMG/NCV performed on June 26, 2014 revealed: Bilateral median sensory mononeuropathy across wrists; Subacute to chronic C5-C6 radiculopathy left; and Chronic C5-C6 cervical radiculopathy right. (Px. 5) Petitioner returned to Dr. Morrell complaining of low back pain traveling into the right leg with numbness to the foot and toes. (Px. 5). Petitioner continued to experience pain in her neck and left shoulder. Dr. Morrell prescribed Duexis and Flector patches along with physical therapy. Dr. Lipov continued to prescribe Lyrica for Petitioner's ongoing cervical and lumbar radiculopathy. (Px. 8).

Petitioner was examined by Dr. Avi Bernstein, a board certified orthopedic surgeon, at the request of the Respondent on June 30, 2014, pursuant to Section 12 of the Act. Dr. Bernstein reviewed medical records, took a history from the Petitioner and performed an evaluation. Dr. Bernstein provided the opinion that the Petitioner suffered sprains and strains to her low and mid back as a result of the

motor vehicle accident. He stated that the herniation found on the MRI scan did not coincide with the patient's symptoms of left lower extremity pain. He stated that the MRI failed to identify any pathology that would explain left upper extremity complaints. He found that the Petitioner was at maximum medical improvement six months after the accident. He stated that there was no reason why Petitioner could not continue her work. (RX1).

MRI of the lumbar spine performed on July 25, 2014 revealed: L1-L2 4-5mm left sided disc herniation with mildly extruded nucleus pulpous indenting the ventral and left side of the thecal sac; L2-L3 6-7mm right sided disc herniation with an extruded nucleus pulpous indenting the right side of the thecal sac; L4-L5 4-5mm right sided disc herniation with mildly extruded nucleus pulpous indenting the right side of the thecal sac. (Px. 5).

On July 28, 2014, Petitioner received a C5-C6 cervical epidural steroid injection which provided 25% improvement of her left hand pain. (Px. 8). On August 18, 2014 Petitioner received a L4-L5 lumbar epidural steroid injection which provided Petitioner 30% improvement in lumbar radicular pain. (Px. 8). Petitioner was referred to Dr. Drake to discuss surgical options along with a referral to a pain psychologist. (Px.8)

Petitioner saw Dr. Brown, a pain psychologist, on September 9, 2014 who recommended increasing her Effexor. (Px 11). On September 15, 2014 Petitioner received a left L2-L3 retrograde lumbar transforaminal epidural injection which provided 70% improvement in her low back pain. (Px. 8).

On September 23, 2014 Petitioner saw Dr. Gregory Drake reporting neck, left arm and low back pain with bilateral lower extremity radiation into the thighs and feet. (Px. 12). Dr. Drake did not believe Petitioner was a candidate for surgery and recommended additional physical therapy. (Px. 12).

Petitioner returned to Dr. Morrell on October 21, 2014 reporting low back pain radiating into the groin and thighs along with neck pain radiating into the left arm and shoulder. (Px. 5). An EMG/NCV of the lower extremities was ordered which revealed "chronic mild right L4-L5 lumbar radiculopathy." (Px. 5).

Dr. Lipov referred Petitioner to Dr. Russ Nockels who examined Petitioner on November 13, 2014 for her ongoing neck, left shoulder and low back pain radiating into her left groin and thigh. (Px. 13). The Petitioner reported an 8 month history of progressive pain to these areas. At that time Petitioner's medications included Flector patch, Lyrica and Effexor. Dr. Nockels ordered cervical/lumbar dynamic x-rays and x-rays of the hips. (Px. 13). The x-rays revealed no abnormal movement and Petitioner was referred to Dr. Troy Buck for a left L1 selective nerve block which was performed on January 7, 2015. (Px. 13). The nerve root injection provided Petitioner with improvement to her left sided groin pain but no improvement to the lumbar spine pain. (Px. 13).

Petitioner testified that she did not work between December 30, 2011 and February 5, 2012. Petitioner testified that she received her normal paycheck during this time period. Petitioner testified that she work four hour days between February 6, 2012 and March 25, 2012. She testified that this paycheck represented 20 hours of work per week. (T.37). Petitioner testified that she returned to work full time on March 26, 2012. Petitioner testified that she had returned to work both in a desk position and calling on customers. (T.46). Petitioner testified that between August 8, 2012 and April 29, 2013, she did not receive any medical treatment. (T.47).

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

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 burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

For treatment of an employee's workplace injury to be compensable under workers' compensation laws, Petitioner must establish the treatment is necessitated by the work injury and not some other cause or condition. *Hansel & Gretel Day Care Center v. Industrial Commission,* (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

Petitioner was involved in a motor vehicle accident on December 29, 2011. The parties agree that this was a work related accident as Petitioner was driving to a home to collect on a default loan.

After her accident, Petitioner treated at the Northwest Community Hospital. The records for treatment at Northwest Community Hospital indicate that there was no deployment of the airbags at the time of the crash and that Petitioner did not lose consciousness. The records indicate Petitioner had complaints of neck and back pain with headaches. The records for treatment at the Northwest Community Hospital indicate the Petitioner underwent a CT Scan of her head, chest and cervical spine. These tests were all unremarkable. Petitioner also underwent x-rays of her chest, pelvis, thoracic and lumbar spines. All the x-rays were unremarkable and revealed no significant abnormality as well. (PX1). Petitioner testified that she was discharged home from the Northwest Community Hospital on December 29, 2011. (T.27).

Petitioner was seen by Dr. Broderick on March 9, 2012. Dr. Broderick assessed the Petitioner with cervicalgia without structural injuries and a herniated disc at L2-3 without convincing evidence of lumbar radiculopathy. (Px.4).

Petitioner underwent a Functional Capacity Evaluation at Accelerated on March 15, 2012. This

revealed that the Petitioner met 100% of the demands of her job as a lending manager. This revealed the Petitioner could function at the sedentary level. (Px.4).

After the motor vehicle accident, Petitioner was off work between December 30, 2011 and February 5, 2012. Petitioner returned to work on a restricted basis between February 6, 2012 and March 25, 2012. Petitioner returned to work full duty on March 26, 2012.

Petitioner treated through August 6, 2012. Petitioner testified that between August 8, 2012 and April 29, 2013, she did not receive any medical treatment. (T.47). The medical records entered into evidence support this testimony.

Petitioner testified that in April of 2013, she began treatment with Dr. Morrell and began to receive physical therapy. Petitioner testified that between April 29, 2013 and June 5, 2013, she underwent physical therapy. (T.47).

The Arbitrator notes that the Petitioner had significant gaps in medical treatment between August 8, 2012 and April 29, 2013, and again between June 5, 2013 and November 18, 2013. The Petitioner was able to work her full duty employment between March 26, 2012 and April 17, 2014.

The findings on the objective testing that Petitioner submitted to changed during the time period before the accident and Petitioner's return to work and after she had been working, not obtaining treatment and her return to treatment. Specifically, the Petitioner underwent an MRI of her cervical spine on January 17, 2012. The report from that MRI was read as revealing that the Petitioner had at C4/5 and C5/6 mild posterior disc spur complexes without canal or foramina narrowing. No significant protrusions were noted. There is no mention of any condition at the C6/7 level.(Px. 4). Conversely, Petitioner underwent a cervical spine MRI at Open MRI on June 11, 2014. This revealed at 2 mm bulge at the C6-7 level without spinal stenosis or significant neuroforaminal narrowing. (Px. 5). Petitioner underwent an EMG/NCV performed by Dr. Brusil on June 26, 2014. This revealed subacute to chronic C5-6 cervical radiculopathy on the left and right sides. No generalized polyneuropathy or other mononeuropathies was noted. (PX. 5). These are new findings at a new level of the cervical spine.

Similarly, Petitioner underwent an MRI of her lumbar spine at Northwest Neurology on January 31, 2012. That was read as revealing a moderate central and right paracentral disk extrusion at L2-3 and a moderate disk bulge at L4-5 causing mild to moderate neuroforaminal stenosis and mild spinal canal stenosis. (Px. 4). Dr. Broderick examined the Petitioner on March 9, 2012. He assessed the Petitioner with a herniated disc at L2-3 without convincing evidence of lumbar radiculopathy. This is supported by the EMG that was performed at Northwest Neurology on February 3, 2012, which revealed no electrodiagnostic evidence of entrapment neuropathy, polyneuropathy or radiculopathy affecting the lower extremities. (Px. 4). Conversely, Petitioner underwent an MRI of her lumbar spine on July 25, 2014. This revealed a disk herniation at L1-2, L2-3 and L4-5. An EMG/NCV was performed on October 30, 2014 at Alexian Brothers. This revealed a chronic right sided, L4-5 radiculopathy. (Px. 5). These are new findings found two years later.

The thoracic spine MRI completed on January 31, 2012 at Northwest Neurology was read as being unremarkable. The Petitioner underwent an MRI of her left shoulder at Open Advanced MRI on June 26, 2012. This revealed findings consistent with tendinitis or a strain. No evidence of a rotator cuff tear or internal derangement of the glenohumeral joint was detected. There were minimal degenerative changes in the AC Joint.

Based on the findings in the medical records and the treatment history, the Arbitrator finds that the Petitioner's condition had reached MMI no later than June 5, 2013. The Arbitrator finds no causal relationship between the Petitioner's current condition and the motor vehicle accident on December 29, 2011.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein. The Arbitrator finds that the Petitioner had reached a point of MMI as of June 5, 2013. The Arbitrator finds that treatment rendered up to June 4, 2013 was reasonable, necessary and related to the Petitioner's work accident. Respondent is responsible for the costs of said treatment. Treatment after June 5, 2013 was not reasonable, necessary or related to Petitioner's work accident on December 29, 2011 and is not the responsibility of the Respondent.

In support of the Arbitrator's decision with regard to the amount due for temporary total disability, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein. The medical records do not support the Petitioner being off work after she had been returned to work following the FCE. The Petitioner underwent a Functional Capacity Evaluation at Accelerated on March 15, 2012. This revealed that the Petitioner met 100% of the demands of her job as a lending manager. (Px. 4). The Petitioner did work full duty between March 26, 2012 and April 17, 2014. The Petitioner's job duties are sedentary in nature. The Petitioner was entitled to TTD from December 30, 2011 through February 5, 2012, when she returned to work part time per doctor's restrictions. Petitioner is entitled to TPD from February 6, 2012 through March 25, 2012, when she was determined to be able to work full time with no restrictions, and did in fact return to work. The Arbitrator does not award any additional TTD benefits.

Respondent is entitled to a credit of $13,950.64 which the parties agree the Respondent has previously paid in TTD benefits. The parties have agreed that the Respondent paid $33,172.12 in short and long term disability benefits and $29,343.38 in medical bills.

In support of the Arbitrator's decision with regard to whether the Petitioner is entitled to any prospective medical treatment, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein. The Petitioner has reached MMI as of June 5, 2012, therefore, no prospective medical treatment is awarded.

ORDER OF THE ARBITRATOR

Medical benefits

Respondent shall pay reasonable and necessary medical services incurred through June 5, 2013, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Partial Disability

Respondent shall pay Petitioner temporary partial disability benefits of $778.00/week for 5.52 weeks, commencing December 29, 2011 through February 5, 2012, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $3,216.40 for the period commencing February 6, 2012 through March 25, 2012 as provided by Section 8(a) of the Act.

Credits

Respondent shall be given credit for $ 29,343.38 for medical benefits paid under Section 8(a) of the Act.

Respondent shall be given a credit of $13,950.64 for TTD benefits paid under Section 8 of the Act.

Robert L. Simpson — June 26, 2015

Signature of Arbitrator — Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Luz Hernandez,
Petitioner,

vs. NO: 13 WC 15438

Ron's Staffing,
Respondent.

16IWCC0376

DECISION AND OPINION ON REVIEW

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

The Commission does correct an error on page six of the Arbitrator's Decision. The Arbitrator, in awarding certain medical bills from the provider Rehab Dynamix, noted in the first paragraph of that section that liability had been established "for dates of service including and between September 3, 2013 and September 25, 2013." However, in the fourth paragraph of the section dedicated to Rehab Dynamix (PX9), the Arbitrator found liability "on the dates of September 3, 2013 and September 25, 2013." The word "on" in paragraph four is hereby replaced with the word "between," to prevent confusion and make the latter paragraph cohere with the Arbitrator's reasoning and intent as expressed by the earlier written finding in paragraph one of that section and supported by the medical evidence referenced by the Arbitrator.

16IWCC0376

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 1, 2015 is hereby affirmed and adopted.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,800.00. 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: JUN 7 - 2016

Joshua D. Luskin

Ruth W. White

Charles J. DeVriendt

o-05/25/16
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

HERNANDEZ, LUZ
Employee/Petitioner

Case# **13WC015438**

RON'S STAFFING
Employer/Respondent

16IWCC0376

On 4/1/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% 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:

4239 THE LAW OFFICE OF JOHN ELIASIK
BRIAN C HERCULE
180 N LASALLE ST SUITE 3700
CHICAGO, IL 60601

4944 KOREY RICHARDSON LLC
NICK TATRO
20 S CLARK ST SUITE 508
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
CORRECTED ARBITRATION DECISION

Luz Hernandez
Employee/Petitioner

v.

Rons' Staffing
Employer/Respondent

Case # **13** WC **015438**

Consolidated cases: _____

16IWCC0376

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **January 28,2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0376

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned $**5,858.06**; the average weekly wage was $**234.32**.

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

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

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

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

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

ORDER

Respondent shall pay to Petitioner reasonable and necessary medical services as invoiced by Illinois Orthopedic Network, Suburban Orthopedics, Rehab Dynamix, Metro Milwaukee Anesthesia and Accredited Ambulatory Care, as outline in the attached decision and as provided in Sections 8(a) and 8.2 of the Act.

Petitioner's request for temporary total disability benefits is hereby denied.

Respondent shall pay Petitioner permanent partial disability benefits of $234.32/week for 11.4 weeks, because the injuries sustained caused the 30% loss of the right middle finger, as provided in Section 8(e) of the Act.

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

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

Findings of Fact

The disputed issues in this matter are: 1) medical bills; 2) temporary total disability; and the nature and extent of Petitioner's injuries. *See*, AX1.

Ron's Staffing Service, ("Respondent") is a temporary staffing agency. Luz Hernandez ("Petitioner") worked for Respondent and was assigned to work at Affy Tapple, a client of Respondent. Petitioner's job duties consisted of placing wooden sticks into apples and putting product onto the apples. On October 10, 2012, Petitioner was walking in the factory when she stepped on a piece of apple that was on the ground and fell to the floor. As a result of this accident, Petitioner hurt her left knee and right hand specifically, the middle finger.

Petitioner was taken to Advocate Occupational Health ("Advocate") on October 10, 2012, complaining of right hand and left knee pain. Petitioner also reported pain in the palm and dorsal digit of her right hand with clicking upon extension of her right middle finger. Petitioner was diagnosed with a right middle finger sprain and a splint was applied. According to the visit note, Petitioner noted moderate pain, which was located in her right middle finger and left knee. Petitioner was released to return to work that day with restrictions of no tight gripping or pinching with the right hand. Petitioner returned to Advocate two more times, each time, Petitioner was given slightly less restrictive work restrictions. There is no note of Petitioner complaining of pain in her wrist. PX1.

Petitioner was referred for to Accelerated Rehabilitation for physical therapy. Her first visit to Accelerated was on October 31, 2012. Petitioner noted that she had pain in the palm and dorsal digit and experienced a clicking in her right middle finger. On November 1, 2012, her second scheduled therapy appointment, Petitioner missed the appointment without excuse. On December 14, 2012, Petitioner was discharged by Accelerated after attending four appointments and missing three. At no time, while treating at Accelerated, did Petitioner complain of pain in her wrist. On December 17, 2012, Respondent sent Petitioner a letter informing Petitioner that they were aware that she had been missing her therapy appointments and that if her absence continued, then Respondent would close her claim. Rx6 & Rx8.

On January 4, 2013, Petitioner saw Dr. Irvin Weisman of Illinois Orthopedic Network, who diagnosed Petitioner as having stenosing tenosynovitis of the right middle finger. Dr. Weisman administered and injection to the middle finger and scheduled her for a follow-up appointment. Dr. Weisman placed Petitioner on light duty restrictions of no lifting over five (5) pounds with the right hand.

On February 1, 2013, Petitioner returned to Dr. Weisman with continued complaints of clicking in her right middle finger. Dr. Weisman recommended Petitioner undergo a release of the A1 pulley muscle of her right middle finger. According to her testimony, Petitioner chose not to go through with the

surgery, out of fear that it would not work. At no time did Petitioner complain of pain in her wrist to Dr. Weisman. RX1 and PX2; Tr. at 20.

Immediately following her accident, Petitioner worked light duty for Respondent, without missing a week, from October 11, 2012 through January 2, 2013. She also worked February 4, 2013 through February 15, 2013. It is recorded that she worked these periods, despite her testimony to the contrary. Mr. Enrique Landeros, Respondent's witness, testified that at all times, while Petitioner was released to light duty until her full duty release in December of 2013, Respondent offered light duty work to Petitioner, yet Petitioner on several occasions stopped working, without explanation. Respondent sent Petitioner two certified letters informing her that work was available, within her restrictions. RX7, RX9 & RX10; Tr. at pp. 15-16, 21-22; 54.

From February 2, 2013 through April 17, 2013, Petitioner did not present to anyone for treatment. According to her testimony, Petitioner contacted Grupo Med Legal, who referred her to Rehab Dynamix. On April 18, 2013, Petitioner presented to Dr. Lee De Las Casas, a chiropractor. According to Dr. Casas' report, Petitioner complained of middle finger pain and, for the first time since her work accident, also complained of pain in her right wrist. According to the report, Petitioner alleged that she experienced immediate pain and swelling in her wrist, following the accident. Dr. Casas diagnosed Petitioner with right finger and wrist pain and right hand internal derangement. Dr. Casas recommended that Petitioner undergo an MRI of her right wrist, which was performed on April 30, 2013. The MRI was read as normal. Dr. Casas further recommended an extended period of chiropractic treatment. PX3, PX5.; Tr. at 25.

On May 21, 2013, Petitioner saw Dr. Axel Vargas, an anesthesiologist at Chicago Pain and Orthopedic Institute. According to Dr. Vargas, Petitioner was diagnosed by Dr. Weisman as having carpal tunnel syndrome and had recommended that Petitioner undergo a carpal tunnel release. Dr. Vargas recommended that Petitioner undergo an EMG/NCV, however the test was not conducted. PX4.

Deposition of Dr. Michael Vender dated December 20, 2013

On July 8, 2013, at the request of Respondent, Petitioner saw Dr. Michael Vender of Hand Surgery Associates. According to Dr. Vender, Petitioner complained of triggering in her right middle finger, as well as diffuse pain in her palm. Dr. Vender diagnosed Petitioner as having flexor stenosing tenosynovitis or, in layman's terms, "trigger finger". Dr. Vender explained that treatment for trigger finger consists of performing a steroid injection and if the steroid injection fails, then surgery would be recommended. In his deposition, Dr. Vender noted that physical therapy is not recommended for such an injury, as such therapy is not beneficial for this particular condition. Following a surgery, Dr. Vender noted that therapy of two times per week for four weeks, would be typical in treating a trigger finger, but no more than three months of post-surgical therapy would be warranted. Dr. Vender further stated that he would not recommend a patient treat with a pain management doctor or with a chiropractor for treatment of a trigger finger. With respect to work restrictions, Dr. Vender noted that

trigger finger does not typically require work restrictions, though he advised that it might be best to avoid repeated, forceful gripping while treating for the condition. RX1.
Petitioner underwent an A1 pulley release of her right middle finger on August 14, 2013. The surgery was performed by Dr. Howard Freedberg of Suburban Orthopaedics. Following the surgery, Petitioner was ordered to begin physical therapy. According to Dr. Freedberg, Petitioner would to be at maximum medical improvement ("MMI") on October 7, 2013. Despite this, Chiropractor Casas continued Petitioner's therapy until December 6, 2013. PX3; PX6.

On November 13, 2013, the therapy done by Rehab Dynamix, following Petitioner's surgery with Dr. Freedberg was submitted to Utilization Review. According to Dr. Edward Rabin, a total of nine (9) post-operative, physical therapy sessions, which took place between September 3, 2013 and September 25, 2013, were deemed to be warranted and all other post-operative physical therapy was deemed to be non-certified. Additionally, the therapy performed by Rehab Dynamix from July 22, 2013 and August 1, 2013 was also deemed to be non-certified. RX2.

Conclusions of Law

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

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

Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill. App. 3d 665, 674 (2009).

Illinois Orthopedic Network (Px8)

The Arbitrator finds that the medical bills of Illinois Orthopedic Network are in line with the recommendations of Dr. Michael Vender and were reasonable and necessary to promote the recovery of Petitioner for her right middle finger injury. Respondent is to pay such medical bills according to the Section 8.2 of the Illinois Workers' Compensation Act and the Medical Fee Schedule.

Rehab Dynamix (Px9)

The Arbitrator finds that the treatment provided by Rehab Dynamix between the dates of September 3, 2013, and September 25, 2013 was reasonable and necessary. All other treatment provided by Rehab Dynamix was neither reasonable nor necessary. Therefore, the Arbitrator finds that Respondent is liable for payment of Rehab Dynamix bills, per the medical fee schedule for dates of service including and between September 3, 2013 and September 25, 2013.

During Petitioner's course of treatment following her work accident of October 10, 2012, through her release on December 6, 2013, Petitioner was seen by three different hand surgeons, i.e., Drs. Weisman, Vender and Freedberg. According to all three, the proper way to treat Petitioner's injury was an A1 pulley release surgery. This course of treatment was recommended on February 1, 2013, but Petitioner refused the surgery, as she testified that she was afraid. The surgery was finally performed on August 14, 2013. Drs. Weisman and Vender were clear and unequivocal that should a steroid injection fail to relieve Petitioner's trigger finger symptoms, the only way to correct the problem would be surgical intervention by way of A1 pulley release. Petitioner rejected this advice and instead saw a chiropractor for her trigger finger. After roughly four months of unsuccessful chiropractic intervention, Petitioner finally acquiesced to the A1 pulley release, which led to her eventual recovery.

Following Petitioner's surgery, the chiropractors at Rehab Dynamix began extensive treatment. Petitioner saw the chiropractor twenty-eight (28) times between September 2013 and December 6, 2013, with no visits between October 2, 2013 and November 4, 2013. Petitioner was seeing the chiropractor as many as five times a week during this period. At most, Dr. Vender recommended treatment at an interval of two times a week for four weeks. Dr. Rabin, the utilization review doctor, recommended certification of only six therapy sessions in the month of September 2013.

Based on the recommendations of Drs. Vender and Rabin, the Arbitrator finds that Respondent is liable for Petitioner's visits to Rehab Dynamix on the dates of September 3, 2013 and September 25, 2013. All other medical care Petitioner received at Rehab Dynamix is deemed unreasonable and

unnecessary and Respondent is not liable for such medical treatment. Respondent will pay the aforementioned compensable medical bills pursuant to Section 8.2 of the Illinois Workers' Compensation Act and the Medical Fee Schedule.

Chicago Pain & Orthopedic Institute (Px10)

The Arbitrator finds that the treatment provided by Chicago Pain & Orthopedic Institute was neither reasonable nor necessary. Therefore, compensation for Chicago Pain & Orthopedic Institutes' medical bills is hereby denied.

According to the report of Dr. Michael Vender, treatment by a pain management doctor for a trigger finger was not warranted. Additionally, a review of the medical records submitted into evidence by Petitioner shows that Petitioner mainly treated with Chicago Pain and Orthopedic Institute for carpal tunnel syndrome. According to Dr. Axel Vargas, Petitioner was diagnosed as having carpal tunnel syndrome by Dr. Weisman; and based on that diagnosis, Dr. Vargas recommended that Petitioner undergo an EMG/NCV. Nowhere in Dr. Weisman's records does it indicate that he diagnosed Petitioner with carpal tunnel syndrome, nor does it note that Petitioner even mentioned pain in her wrist. It is unclear where Dr. Vargas obtained his information with respect to Petitioner's past diagnoses and clearly, the care rendered by Dr. Vargas was neither reasonable nor necessary for, as noted above, all surgeons who treated Petitioner agreed that Petitioner suffered from trigger finger, not carpal tunnel syndrome.

It is for these reasons that the Arbitrator finds that the treatment provided by Chicago Pain & Orthopedic Institute was neither reasonable nor necessary. Therefore, compensation for Chicago Pain & Orthopedic Institutes' medical bills is hereby denied.

Advantage Imaging (Px11)

The Arbitrator finds that the treatment provided by Advantage Imaging was neither reasonable nor necessary. Therefore, compensation for Advantage Imaging's medical bills is hereby denied.

On April 30, 2013, Petitioner underwent an MRI of her right wrist, which was read as normal. As previously noted, the medical records do not support Petitioner suffering an injury to her wrist. According to the medical records, Petitioner never complained of pain in her wrist until her first visit with Rehab Dynamix, which took place over six months following her work accident. Prior to her first visit with Rehab Dynamix, Petitioner had been seen by medical staff at Advocate Occupational Health, Accelerated Rehabilitation; and by Dr. Weisman. She never told any of these medical professionals that she was experiencing pain in her wrist. The Arbitrator concludes that Petitioner has not proven, by a preponderance of the evidence, that she suffered an injury to her right wrist, as a result of her work accident. It is for these reasons that the Arbitrator finds that the treatment provided by Advantage Imaging was neither reasonable nor necessary and compensation for Advantage Imaging's medical bills is hereby denied.

Suburban Orthopaedics, LLC (Px12)
The Arbitrator finds that the medical bills of Suburban Orthopadics, LLC are in line with the recommendations of Dr. Michael Vender and were reasonable and necessary to promote the recovery of Petitioner for her right middle finger injury. Respondent is to pay such medical bills according to the Section 8.2 of the Illinois Workers' Compensation Act and the Medical Fee Schedule.

Holy Cross Hospital (Px13)
The Arbitrator declines to award Petitioner payment of the medical bills from Holy Cross Hospital, as Petitioner did not prove, by a preponderance of the evidence, that these bills were related to her work accident. Petitioner did not submit any supporting medical records into evidence regarding these bills. It is unclear what treatment Petitioner received at Holy Cross Hospital and why she received this treatment. Nowhere in any other medical records submitted into evidence is the treatment at Holy Cross Hospital discussed or even alluded to. The Arbitrator is unable to determine whether this treatment was even recommended by any of Petitioner's treating physicians or was calculated to promote Petitioner's recovery from her work accident of October 10, 2012. Having failed to carry her burden with respect to the medical bills from Holy Cross Hospital, the Arbitrator concludes that Respondent is not liable for payment of said bills.

Metro Milwaukee Anesthesia Associates (Px14)
The Arbitrator finds that the medical bills of Metro Milwaukee Anesthesia Associates are in line with the recommendations of Dr. Michael Vender and were reasonable and necessary to promote the recovery of Petitioner for her right middle finger injury. Respondent is to pay such medical bills according to the Section 8.2 of the Illinois Workers' Compensation Act and the Medical Fee Schedule.

Accredited Ambulatory Care, LLC (Px15)
The Arbitrator finds that the medical bills of Accredited Ambulatory Care, LLC. are in line with the recommendations of Dr. Michael Vender and were reasonable and necessary to promote the recovery of Petitioner for her right middle finger injury. Respondent is to pay such medical bills according to the Section 8.2 of the Illinois Workers' Compensation Act and the Medical Fee Schedule.

Prescription Partners, LLC (Px16)
The Arbitrator finds that the treatment provided by Prescription Partners, LLC was neither reasonable nor necessary. Therefore, compensation for Prescription Partners, LLC's medical bills is hereby denied.

According to the report of Dr. Michael Vender, treatment by a pain management doctor for a trigger finger was not warranted. As noted above, the treatment rendered by Dr. Axel Vargas of Chicago Pain and Orthopedic Institute was neither reasonable nor necessary. The prescriptions dispensed by Prescription Partners, LLC on May 21, 2013 and July 25, 2103 were dispensed at the direction of Dr.

Axel Vargas. Therefore, the medical bills pertaining to those dates of services are hereby found to be neither reasonable nor necessary.

With respect to medications dispensed ostensibly at the request of Dr. Freedberg, on August 12, 2013, the record does not contain medical records evidencing a visit to Dr. Freedberg by Petitioner on that date. Therefore, Petitioner has failed to carry her burden of proof with respect to these bills.

It is for these reasons that the Arbitrator finds that the treatment provided by Prescription Partners, LLC was neither reasonable nor necessary. Therefore, compensation for Prescription Partners, LLC's medical bills is hereby denied.

Cardiac Billing Services (Px17)

The Arbitrator declines to award to Petitioner payment of the medical bills from Cardiac Billing Services, as Petitioner has not proven, by a preponderance of the evidence, that these bills are related to her work accident. Petitioner did not submit any supporting medical records into evidence whatsoever. It is unclear what treatment Petitioner received at Cardiac Billing Services and why she received this treatment. Nowhere in any other medical records submitted into evidence is the treatment with Cardiac Billing Services discussed or referenced. The Arbitrator is unable to determine whether this treatment was even recommended by any of Petitioner's treating physicians or was calculated to promote Petitioner's recovery from her work accident of October 10, 2012. Having failed to carry her burden with respect to the medical bills from Cardiac Billing Services, the Arbitrator concludes that Respondent is not liable for payment of said bills.

Community Pathology Associates, LLC (Px18)

The Arbitrator declines to award to Petitioner payment of the medical bills from Community Pathology Associates, LLC as Petitioner has not proven, by a preponderance of the evidence, that these bills are related to her work accident. Petitioner did not submit any supporting medical records into evidence. It is unclear what treatment Petitioner received at Community Pathology Associates, LLC and why she received this treatment. Nowhere in any other medical records submitted into evidence is the treatment with Community Pathology Associates, LLC discussed or referenced. The Arbitrator is unable to determine whether this treatment was even recommended by any of Petitioner's treating physicians or was calculated to promote Petitioner's recovery from her work accident of October 10, 2012. Having failed to carry her burden with respect to the medical bills from Community Pathology, LLC, the Arbitrator concludes that Respondent is not liable for payment of said bills.

K. Is Petitioner entitled to TTD benefits?

The Arbitrator concludes that Petitioner has failed to carry her burden of proof with respect to entitlement of temporary total disability benefits ("TTD"). Therefore, the Arbitrator declines to award any TTD benefits.

According to Petitioner's testimony, Petitioner admits that following her accident she did indeed work some periods of light duty work; however, Petitioner's testimony with respect to the issue of entitlement to TTD is varied and at times contradicting. During testimony the following exchange occurred:

Q. Okay. You continued working until about November 12[, 2012]; is that right?
A. Yes.
Q. Why did you stop working on November 12th?
A. Because my hand was hurting a lot.
Q. You were able to work with those restrictions for a period of time, right?
A. Yes.
Q. In November, you stopped working, right?
A. In December, yes.

Tr. at 15-16.

This type of confusing testimony characterized Petitioner's testimony, and it was clear that Petitioner could not accurately recall what dates, if any, that she worked following her work accident. Petitioner later testified that she worked three days in February of 2013 and went back to work on October 7, 2013. *Id.* at 21-22. According to Petitioner's post-accident wage records, Petitioner worked without interruption following her work accident through December of 2012. Petitioner then worked the first and second weeks of February 2013 and the final week of March of 2013. Based on the aforementioned wage records, Petitioner returned to work permanently beginning in early October of 2013.

According to the Request for Hearing form, submitted into evidence as Arbitrator's Exhibit 1, Petitioner claimed to be entitled to TTD for the periods of November 12, 2012 through December 16, 2012; December 30, 2012 through February 7, 2013 and February 15, 2013 through December 6, 2013. Based on Petitioner's post-accident wage records, it is undisputed that Petitioner worked for Respondent for the periods of November 12, 2012 through December 16, 2012 and October 6, 2013 through December 6, 2013; therefore, Petitioner's request for TTD for those periods is summarily denied.

With respect to the period of December 30, 2012 through February 7, 2013, it is true that Petitioner did not work for Respondent during that period. Despite not working, the record is devoid of any doctor's note that orders Petitioner to be off work for that time. Additionally, Dr. Vender stated that Petitioner was capable of working, without restrictions, following her accident. According to the testimony of Respondent's representative, Enrique Landeros, Respondent was able to provide

Petitioner with work, at all times, following Petitioner's work accident. It is for these reasons that the Arbitrator denies Petitioner's request for TTD for the period of December 30, 2012 through February 7, 2013.

With respect to the period of February 15, 2013 through October 6, 2013, it is also true that Petitioner did not work for Respondent during that period. Again, according to Dr. Vender, Petitioner was capable of working at near full capacity, following her work accident. Additionally, Respondent wrote two separate letters notifying Petitioner that they had work available for her and that she should return to work. Petitioner neither presented herself to work for Respondent nor provided Respondent with medical status notes indicating that she could not work. Therefore, Petitioner's request for TTD for the period of February 15, 2013 through October 6, 2013, is denied. Having failed to prove entitlement to TTD, the Arbitrator denies Petitioner's request for TTD in its entirety.

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

As a result of Petitioner's work injury Petitioner suffered an injury to her right middle finger. According to the diagnosis of her treating doctors, Petitioner suffered from flexor stenosing tenosynovitis or, "trigger finger." After Dr. Freedberg performed a release of the A1 pulley of Petitioner's middle finger and a short course of physical therapy, Petitioner achieved MMI and has since returned to her pre-injury job.

In *Rose Valdez v. Intercontinental Hotel*, 01 IIC 0308, (Ind. Com'n 2001), Valdez suffered an injury to her thumb, which resulted in a diagnosis of stenosing tenosynovitis, or trigger finger. Petitioner was treated with a surgical release of her A1 pulley as well as a short course of physical therapy. Upon the completion of treatment, Valdez was able to return to her pre-injury job. Following a hearing, the Arbitrator awarded, and the Commission affirmed, 30% loss of use of Petitioner's thumb.

Given the striking similarities between the case at hand and that of *Valdez*, the Arbitrator awards Petitioner 30% loss of use of her right middle finger, or 11.4 weeks of permanent partial disability.

16IWCC0376

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC15438
SIGNATURE PAGE

L Thompson

Signature of Arbitrator

April 1, 2015
Date of Decision

APR 1 - 2015

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

Kenneth W. Johnson,
Petitioner,

vs. NO: 05 WC 17118

Evanston Township High School,
Respondent.

16IWCC0377

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 Petitioner's issues of casual connection, medical expenses, prospective medical expenses, temporary total disability and credit applicable for same, and admissibility of the evidence deposition of Dr. Avi Bernstein, and being advised of the facts and law, affirms and adopts the facts and reasoning expressed in the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In so affirming, the Commission does correct an internal inconsistency contained within the Decision. Specifically, on the second page of the Decision cover sheet, under the "Findings" heading the Arbitrator notes the Respondent shall be given a credit of $4,991.91 for TTD; however, in the "Order" section later on that page, the Arbitrator notes the Respondent shall be given a credit of $5,207.16 in TTD payments. This inconsistency is effectively reiterated on page 12 of the rider of the Decision, with $4,991.91 being listed as a conclusion in the 8(j) analysis section and $5,207.16 being expressed in the "Order of the Arbitrator" section.

The Commission has reviewed Respondent's Exhibit 1 and the testimony of Shirley McGill, which support the $5,207.16 figure, and further notes that the $4,991.91 asserted by the claimant lacks independent factual corroboration. The Commission finds that the proper amount of TTD benefits paid by the Respondent for which the Respondent would be entitled to credit is $5,207.16. The Arbitrator found the Respondent liable for 11 & 5/7 weeks of TTD, a total liability of $5,256.43, thereby leaving present liability of $49.27 due and owing for TTD once the credit is applied.

16IWCC0377

Beyond resolution of the above-referenced discrepancy, all other findings and orders are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that other than expressed above, the Decision of the Arbitrator filed January 29, 2015, 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.

The party commencing 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: JUN 7 - 2016

Joshua D. Luskin

o-05/25/16
jdl/wj
68

Charles J. DeVriendt

Ruth W. White

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

JOHNSON, KENNETH
Employee/Petitioner

Case# 05WC017118

EVANSTON TOWNSHIP HIGH SCHOOL
Employer/Respondent

16IWCC0377

On 1/29/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0728 THE LAW OFFICES OF THOMAS DUDA
330 W COLFAX ST
PALATINE, IL 60067

1120 BRADY CONNOLLY & MASUDA PC
NICOLE RUSSO WEISBRODT
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kenneth Johnson
Employee/Petitioner

v.

Evanston Township High School
Employer/Respondent

Case # 05 WC 17118

Consolidated cases: ____

16IWCC0377

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **December 12, 2012 and December 4, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

16IWCC0377

On the date of accident, 1/23/05, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned $673.08; the average weekly wage was $35,000.00.

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

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

Respondent shall be given a credit of $4,991.91 for TTD, $0.00 for TPD, $0.00 for maintenance, and $3,919.18 for other benefits, for a total credit of $8,911.09.

Respondent is entitled to a credit of $101,316.95 under Section 8(j) of the Act.

ORDER

Credits

Respondent shall be given a credit of $5,207.16 for TTD, $0.00 for TPD, and $0.00 for maintenance benefits, for a total credit of $$5,207.16.

Respondent shall be given a credit of $101,316.95 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall be given credit for $3,919.18 for **medical** benefits paid under Section 8(a) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $448.72/week for 11 and 5/7 weeks, commencing 1/23/05 through 4/15/05, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $403.85/week for 20 weeks, because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

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

Deborah L. Simpson
Signature of Arbitrator

Jan 28, 2015
Date

ICArbDec19(b)

JAN 29 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Johnson,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 05 WC 17118**
	)	
Evanston Township,	)	
	)	**16IWCC0377**
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on January 23, 2005, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that on that date, the Petitioner sustained accidental injuries that arose out of and in the course of the employment and that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $35,000.00, and that his average weekly wage was $673.08.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) Is the Respondent liable for the unpaid medical bills; (3) Is Petitioner entitled to TTD from January 23, 2005 through the present; (4) What is the amount of TTD that Respondent has paid Petitioner; (5) What is the nature and extent of the injury; (6) Has Petitioner exceeded his choice of medical providers; (7) Is Respondent entitled to credit pursuant to 8(j); and (9) Is the evidence deposition of Avi Bernstein, M.D. admissible.

STATEMENT OF FACTS

The issue of the Admissibility of the Evidence Deposition of Avi Bernstein, M.D.

On December 12, 2012, prior to commencement of testimony the parties requested a ruling regarding the issue of the evidence deposition of Avi Bernstein, M.D. (Transcript of Arbitration 5, hereinafter "T.A." 5). Preliminary arguments from attorneys for petitioner and respondent addressed the issue of a Dedimus Motion pertaining to the deposition of respondent's expert, Dr. Avi Bernstein. Petitioner's attorney argued that in response to the Dedimus Motion, it stated that Dr. Bernstein's deposition was scheduled in advance for September 25, 2012, at 12:00 p.m. (T.A. 8). Petitioner's attorney acknowledged that on the August 27, 2012, hearing date for this case, that the Dedimus Order was granted by Arbitrator Falcioni and that petitioner's

attorney declined making a record of the granted Dedimus. (T.A. 8). Petitioner argued that prior to securing the deposition date referenced in the Dedimus, that no one contacted him regarding availability for that date. (T.A. 8). Petitioner's attorney testified that when the start time of the deposition on September 25, 2012, was later delayed by the doctor, that it conflicted with his personal religious holiday, because he had to be "home to take care of my chores." (T.A. 9). Petitioner's attorney stated that he appeared for Dr. Bernstein's deposition on September 25, 2012, at 12:00 p.m., although he had already been informed the doctor was unable to proceed with the deposition at that time. (T.A. 11).

Respondent's attorney noted on the record that the Dedimus Motion presented on August 27, 2012, referenced a pre-scheduled deposition date. (T.A. 19). That was in accordance with the rules for preparing a Motion, which require identification of a deposition date. (T.A. 19). Respondent's attorney explained that a deposition date was secured for the Motion so that it could be presented as part of the Motion pursuant to the rules. (T.A. 20). Respondent's attorney also explained that the 12:00 p.m. start time for the deposition which was referenced in the Dedimus Motion was the time provided by the doctor's office. The doctor's schedule subsequently changed, beyond the control of the respondent or its attorney. (T.A. 20). Respondent's attorney noted that the Dedimus Order signed by Arbitrator Falcioni on August 27, 2012, granted the Motion for Dedimus on September 25, 2012, and did not specify a time that the deposition was to be completed on that date. (T.A. 20). Respondent's attorney reported that the time change was a 2 hour difference, to accommodate a surgery at the doctor's request. (T.A. 20). After the September 25, 2012, deposition date had to be rescheduled because the petitioner's attorney could not attend the 2:00 p.m. time, respondent's attorney did not consult petitioner's attorney regarding a new date. Respondent's attorney noted on the record that the alternative dates in February or March were provided by the doctor's office, and not requested or provided by the Respondent's attorney's office and these were offered to the petitioner's attorney. (T.A. 21). Respondent's attorney stated that she exhausted efforts to secure a sooner date, which is how the new deposition date of November 28, 2012, was obtained. (T.A. 22).

Respondent contended that the Dedimus Order granted addresses whether the deposition itself should be permitted, and is not intended to be a time specific Order. (T.A. 22). Respondent's attorney stated that when the new deposition date of November 28, 2012, was secured from Dr. Bernstein's office, it only became available due to a cancellation. (T.A. 22). The date had to be reserved without consulting petitioner's attorney, or it would have been lost. (T.A. 22). Notice of the November 28, 2012, deposition date of Dr. Bernstein was sent to petitioner's attorney on October 9, 2012, more than 7 weeks in advance. (T.A. 22). Petitioner's attorney had more than 7 weeks before the deposition to voice any objection to the availability for the November 28, 2012, deposition date. Respondent's attorney argued that by the time the petitioner finally raised an objection on November 14, 2012, Arbitrator Simpson's (October) trial cycle had ended, and there was no one available to hear an Emergency Amended Dedimus Motion. (T.A. 22). The parties did not attempt to contact Arbitrator Simpson to see if they could present the emergency motion. Respondent's attorney also noted that regarding the November 28, 2012, deposition date that she inquired from petitioner's attorney whether he had a conflict with that date. He denied a scheduling conflict, and stated that he was objecting to the deposition. (T.A. 23). Respondent's attorney provided documentation confirming that she

contacted petitioner's attorney regarding the change in deposition time the same day that Dr. Bernstein's office notified respondent's attorney of the modified time. (T.A. 27).

Petitioner's attorney admitted that he did not advise respondent's attorney of a conflict with the November 28, 2012, deposition date, but he advised counsel that he was "standing on the Dedimus." (T.A. 32).

Arbitrator Simpson requested that the parties brief the issue of whether or not to allow the partial testimony from Dr. Bernstein into evidence with Briefs being due on January 4, 2013. The parties elected to proceed with the testimony of the Petitioner on December 12, 2012. After the testimony was completed the hearing was recessed until January 4, 2013, for submission of briefs on the issue and to potentially close proofs.

After the briefs were submitted, Arbitrator Simpson ruled that the balance of the deposition of Dr. Bernstein should go forward and that the deposition would be admissible in its entirety. The proofs were kept open until the parties could secure a date for the completion of the deposition of Dr. Bernstein. The parties agreed to a date of April 17, 2013, beginning with cross-examination by Petitioner's attorney since the Respondent had proceeded to take the deposition of Dr. Bernstein on Nov. 28, 2012, the date it had been re-scheduled to and petitioner's counsel had declined to appear.

The accident of January 23, 2005

Petitioner testified that on the day of his accident he was employed as a Custodian for Evanston Township High School. (T.A. 47). Petitioner testified that in 2005, besides being a Custodian, he also had responsibilities for maintaining the outside grounds. (T.A. 48). Petitioner testified that his outside duties included plowing snow, shoveling snow, and maintaining areas that needed to be salted. (T.A. 48). Petitioner testified that on January 23, 2005, the date of accident, he was plowing snow from the driveways and sidewalks at the school. (T.A. 49). He stated that he was operating a tractor that was used for cutting grass and plowing snow. (T.A. 49). He described it as approximately 4 feet long with a V-plow on it. (T.A. 50). He stated that the seat area was enclosed with steel doors and glass on both sides. (T.A. 50).

He testified that as he was plowing snow, going south, there was a place where concrete separated from the ground, which he struck with the plow. (T.A. 52). Petitioner testified that when he struck the concrete, it jerked him, and he struck the front of the glass, bounced back, and hit the back of the glass. (T.A. 52). Petitioner testified that the vehicle stopped when the accident occurred. (T.A. 55). Petitioner testified that after the incident he noticed that he couldn't raise his arms up, and that he had pain in his head and arms. (T.A. 57). He stated that a co-worker assisted him from getting out of the snowplow and that he tried to take the machine back to the office where they are stored. (T.A. 57). Petitioner testified that he then went to the security room, where he laid down on the couch for a minute, and then decided to call an ambulance. (T.A. 58). Petitioner was then taken to the emergency room at Evanston Hospital. (T.A. 58). Petitioner described subsequent pain in his lower back, pain in his shoulders, and a headache. (T.A. 59). Petitioner testified that he did not return to work for the school district after the alleged accident date. (T.A. 60).

Petitioner testified that two days following his alleged accident, he began experiencing more heart problems. (T.A. 61). He developed shortness of breath, but continued attending physical therapy through the beginning of April 2005. (T.A. 62). The petitioner testified that he also treated with Dr. Pierre, a chiropractor, between January and April of 2005. (T.A. 62). The petitioner testified that his wife was a patient of Dr. Pierre. (T.A. 63). However, petitioner testified that the chiropractic treatments actually made his pain worse, and irritated his symptoms. (T.A. 63).

Petitioner acknowledged that he did have some medical problems prior to the alleged January 23, 2005, accident date. He admitted that he had been having heart failure and was treating with Dr. Vernof. (T.A. 51). Petitioner testified that he was treating with Dr. Vernof for his shortness of breath and heart problems, as well as his neck and back pain. (T.A. 64). The petitioner testified that he was sent to Evanston Hospital by Dr. Vernof, and that he was admitted on April 1, 2005, for his heart condition. (T.A. 64). Petitioner testified that he remained hospitalized at Evanston Hospital for 3 to 4 weeks due to his heart condition. Petitioner testified that eventually he was transferred to Northwestern Memorial Hospital for treatment of his heart condition for consideration for a heart transplant. (T.A. 65). He was then transferred to Loyola Hospital, where he began treating with a cardiologist, Dr. Heroux. (T.A. 66). The petitioner was hospitalized between August and October 2005 for preparation and completion of a heart transplant. (T.A. 67). He was released to his home at the end of 2005. (T.A. 67). Petitioner acknowledged that at some point, his sister was contacted by the school district, and that he received written documentation to resign from his position at the school district while he was in Northwestern Memorial Hospital. (T.A. 68). The petitioner acknowledged that as the summer of 2005, he voluntarily resigned from his employment with the school district. (T.A. 68). The petitioner underwent a heart transplant on June 8, 2006. (T.A. 69). He was hospitalized intermittently subsequent to the heart transplant surgery due to complications pertaining to the transplant. (T.A. 69-70). The petitioner continued treatment throughout 2007 regarding his heart condition. (T.A. 70).

At the request of his attorney, petitioner was examined by Dr. Gross in 2007. Petitioner began treating with Dr. Nockels in 2008 for his alleged neck condition. This was more than 3 years following the alleged work incident. Petitioner underwent surgery performed by Dr. Nockels on July 28, 2008. (T.A. 72). Petitioner described that currently he continues to have pain in both sides of his neck, and has difficulty turning his neck to either side. (T.A. 76). The petitioner also described difficulty carrying things.

Petitioner reviewed a written job description for the custodian position, and testified that it was an accurate description of what his job duties for the respondent were. (T.A. 79). On cross-examination, petitioner admitted that he had a previous injury to his neck and back in 2003, but he denied being able to recall prior treatment in 2003 at Loyola Hospital. (T.A. 80).

Records introduced into evidence by respondent document and upon further questioning, petitioner admitted that he did sustain an injury to his neck and back when he fell off a ladder in 2003. (T.A. 80). Petitioner admitted that he treated at Evanston Northwestern for several months following the injury in 2003. The records reflected as a result of his alleged injury in 2003, he had MRIs done of his neck and back. Petitioner acknowledged having undergone physical therapy for his neck and back in 2003. (T.A. 81).

On cross-examination, petitioner agreed that he had seen Dr. Alleva for treatment for the injuries he sustained on January 23, 2005, regarding his neck and thought he recalled that he had been released to full duty work in April 2005 regarding his neck. (T.A. 82). The records of Dr. Pierre dated March 10, 2005, indicate that "my recommendation is full duty, no restrictions." (T.A. 82, P.X. 6). Petitioner denied returning to full duty work for the school district at that time, but admitted that he had already been experiencing heart problems at the time he had been released for his neck. (T.A. 83).

Petitioner admitted that he applied for disability benefits through the school district in June of 2005. (T.A. 83). He acknowledged his signature on an Application for Disability Benefits dated June 7, 2005. (T.A. 83-84). Petitioner testified that he was granted disability benefits and took a leave from work subsequently. (T.A. 84). Petitioner could not testify to any treatment for his injuries from the accident of January 23, 2005, between the period of his release by Dr. Pierre in March of 2005, and his being sent to Dr. Gross by his attorney in July 2007. (T.A. 86). The records entered into evidence on petitioner's behalf fail to document any treatment in the two year period between 2005 and 2008 as well.

The petitioner agreed that once he resumed treating for his neck, the first doctor he saw was Dr. Gross, who he was sent to by his attorney. He did not return to any of his prior treating doctor's.

Petitioner was also sent for an examination by Dr. Gary Skaletsky, at the request of his attorney. (T.A. 77). Despite the fact that he did not examine the petitioner until more than four and a half years after the alleged January 23, 2005 accident, Dr. Skaletsky rendered an opinion that petitioner was incapable of working at all during the period between his alleged work injury in January 2005 and his surgery performed by Dr. Nockels in July 2008. This is inconsistent with the full duty releases from petitioner's treating physicians, Dr. Alleva, and Dr. Pierre, as well as the Respondent's expert, Dr. Bernstein.

Dr. Skaletsky admitted during his deposition that the EMG study performed in 2003 would have been ordered to address preexisting radicular complaints, and also that the cervical MRI studies from 2003 and 2005 were essentially unchanged. (PX. 19, p. 29). Dr. Skaletsky also acknowledged that there was no evidence of any cervical spine treatment for the period between petitioner's release from Dr. Pierre in March 2005, and the first consultation with Dr. Nockels in March 2008. (PX. 19, p. 32). Dr. Skaletsky also acknowledged that none of the doctors who treated petitioner's alleged cervical injury prior to 2008 had ever recommended surgery. (PX. 19, p. 33).

From the January 2005 date of accident to the first treatment with Dr. Nockels in 2008, the treating medical records indicate that no prior doctor had recommended cervical surgery regarding petitioner's alleged work injury. The petitioner testified that at some point he applied for Social Security Disability and that he had been awarded it and was receiving it at the time of trial. At the time of trial, petitioner stated that he had not received any treatment regarding his neck for the past year. (T.A. 90).

The Petitioner apparently related to Dr. Gross and Dr. Nockels that his pain began three years ago with an injury at work. However the neurosurgery admission/consult notes read in relevant part that:

> III. HISTORY OF PRESENT ILLNESS
>
> 51 year old right handed male s/p heart transplant in 2006 with a three year history of neck pain after injuring himself at work. While undergoing a heart biopsy a few months ago the patient heard a "snap" in his neck and has had difficulty turning his head to the left ever since. The patient describes his pain as starting in the left side of his neck and radiating to the entire arm. The patient states he has pain in his left shoulder. (PX 15)

Dr. Bernstein examined the petitioner at the request of the respondent on April 15, 2005, and again on March 1, 2010. (RX 15, p. 33). Dr. Bernstein is a board certified orthopedic surgeon specializing in treatment of the spine. (RX. 15, p. 12). He is also vice chairman of orthopedic surgery at Lutheran General Hospital and the director of spine trauma at Lutheran General Hospital. (RX. 15, p. 12). Dr. Bernstein testified that he has performed approximately 2,000 cervical operations during his career. (RX. 15, p. 13). Dr. Bernstein testified that as part of his practice, he regularly reviewed diagnostic studies such as CT scans, x-rays, and MRI scans. (RX. 15, p. 13).

Dr. Bernstein testified that he first examined the petitioner on April 15, 2005. Petitioner gave a history, stating that in January of 2005, he struck the sidewall of a sewer causing him to be knocked forward and backwards, snapping his head and neck and the subsequent medical treatment for his injury. (RX 15, p. 16). Petitioner gave Dr. Bernstein a history of his non-related heart condition, including a pacing abnormality as well. (RX. 15, p. 16). Petitioner complained of posterior neck pain, radiating into the left shoulder. (RX. 15, p. 17). Dr. Bernstein conducted a physical examination of the petitioner on that date, and found the petitioner had very good range of motion consistent with his age. No tenderness was noted, and petitioner demonstrated a completely normal neurological evaluation. (RX. 15, p. 17). Dr. Bernstein further testified that based upon his review of the petitioner's history, his subjective complaints, the clinical findings of Dr. Bernstein's examination, and the medical records reviewed, that he felt petitioner had some degeneration in his neck, and that he likely suffered a cervical strain or temporary aggravation of the degenerative condition. (RX 15, p. 18). Dr. Bernstein felt that petitioner had a completely benign physical examination and that he was capable of performing unrestricted activity once his heart condition resolved. (RX 15, p. 18).

Dr. Bernstein reviewed the medical examination report of petitioner's first expert, Dr. Michael Gross, who examined the petitioner on July 11, 2007. The record notes that Dr. Gross testified that 90% of his independent medical examination work is performed on behalf of petitioners, and that he is only board certified in Urgent Care Medicine, not orthopedics. Dr. Bernstein felt this was relevant because he would not consider Dr. Gross an expert in cervical spine conditions, cervical neuropathy, and the treatment of cervical conditions. (RX. 15, p. 21). Dr. Bernstein also noted that it did not appear that Dr. Gross had reviewed any medical records from other treating physicians. Dr. Bernstein felt that it was significant because Dr. Gross would have been simply relying on the petitioner's history alone, not getting complete assessment of

the timeline and positions of other doctors. (RX. 15, p. 22). Dr. Bernstein testified that, "...in terms of causation, I don't feel any of those conditions were caused by his work incident or that any of his care or treatment was in any way – and surgical treatment was in any way the result of his work incident." (RX. 15, p. 23).

Dr. Bernstein specified in his testimony regarding petitioner's 2007 cervical fusion performed by Dr. Nockels "that operation was not done for neck pain. It was done for the condition of spinal stenosis and spinal cord compression, and those diagnoses are a result of a chronic degenerative condition and were in no way caused by the work accident." (RX. 15, p. 26). Rather, Dr. Bernstein testified that, "in March of 2008 when there was an acute exacerbation and complaints of neck pain and symptoms related to the neck, and that's what really brought him to the attention of Dr. Nockels and the subsequent workup and surgery, so I see that as a new symptomatic condition at that point in time unrelated to his work incident." (RX. 15, p. 27).

Dr. Bernstein examined Petitioner again on March 1, 2010. (R.X. 15, p. 33). At the second examination, Petitioner gave a history to Dr. Bernstein that the surgery actually made his complaints worse. (RX. 15, p. 34). Dr. Bernstein also testified that at his second exam, Petitioner had much more limited cervical range of motion, and muscle atrophy, as a result of the cervical fusion. (RX. 15, p.35). Dr. Bernstein later had the opportunity to review diagnostic studies and films from both before and after the alleged date of accident. Dr. Bernstein testified that the MRI films showed no evidence of any acute herniation or tear. He testified that his diagnosis was a temporary aggravation of a degenerative condition or cervical strain. (RX. 15, p. 43). He concluded that Petitioner's cervical surgery "has nothing to do with the accident whatsoever; and, furthermore, the surgery that was performed was performed for the intention of relieving cord compression, and not for the purposes of relieving neck pain." (RX. 15, p. 44).

Shirley McGill, from Sedgwick Claims Management, testified on behalf of Respondent regarding TTD payments made to the Petitioner. She testified that Petitioner's claim was originally being administered by Gallagher Bassett at the time that TTD benefits were issued in 2005, but that the data regarding dates and amounts paid was transferred over to Cambridge on August 26, 2006, when the Sedgwick assumed management of the previous administrator, Cambridge Integrated Services Group. Ms. McGill testified that the payment screens were kept in the normal course of business, and document that a total of $5,207.16 in TTD benefits was paid to the petitioner. (RX 1) She testified that at no time during the course of her handling of the file, was a claim for underpayment of TTD made by petitioner or his attorney.

Ms. McGill was not able to provide any information as to how the document was prepared, when payments were made or to whom payments were made. According to Ms. McGill and the documents, only three checks were made payable to the Petitioner, Mr. Johnson, they were in the amount of $607.52 and were purportedly for two weeks of TTD benefits. The parties stipulated that the Petitioner's average weekly wage was $673.08, which would amount to a TTD rate of $448.72 per week or $897.44 for a two week period.

The Petitioner stipulated that he had received TTD payments in the amount of $4,999.91 and that $3,919.18, was paid by respondent toward the medical bills. No clear evidence was produced with respect to how petitioner arrived at those figures either.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,*58 Ill. 2d 226, 317 N.E.2d 515 (1974)

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

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 burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

On the issue of an intervening cause, the courts have consistently held that for an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition. *Boatman v. Industrial Commission,* 256 Ill.App.3d 1070, 628 N.E.2d 829, 195 Ill.Dec. 365 (1st Dist. 1993).

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The arbitrator concludes that petitioner's present condition of ill-being is not causally related to the petitioner's alleged January 23, 2005, injury.

Petitioner failed to present medical evidence or opinion testimony sufficient to prove by a preponderance of the evidence causally connecting his lower back symptoms to the work injury of January 23, 2005. The treating medical records from both Dr. Pierre and Dr. Alleva release petitioner to return to full duty work regarding his cervical spine in March 2005 and April 2005, respectively. (P.X. 6, P.X. 7). Dr. Pierre's office note dated March 10, 2005 states, "ROM is restored...no restrictions, no inflammation, and no radicular symptoms. My recommendation is full duty with no restrictions." P.X. 6.

Following his examination on April 15, 2005, and his review of medical records, Dr. Bernstein opined that the petitioner had reached maximum medical improvement for his work

related cervical strain and temporary aggravation of his preexisting degenerative cervical spine. (R.X. 6). Dr. Bernstein also noted that Petitioner had very good cervical range of motion consistent with his age, no tenderness, and a "completely normal neurological evaluation." (R. X. 15, p. 17).

The only physicians who gave causation opinions in support of petitioner's position were Dr. Gross and Dr. Skaletsky, neither of whom were treating physicians. Petitioner did not return to his doctors that had treated him prior to the heart transplant when he was released, rather, Petitioner was seen by both Dr. Gross and Dr. Skaletsky. At the time Dr. Gross examined petitioner, he was not board certified in any areas of medicine, and he testified that he does not perform any surgeries, apart from minor surgeries in the emergency room. (P.X.14 p. 7,8, 28). Dr. Gross also testified that he had not performed any spinal or cervical surgeries in over 20 years. (P.X. 14, p. 28). Dr. Gross only examined petitioner on one occasion, more than two and a half years after the alleged accident date. (P.X. 14, p. 30).

Similarly, the petitioner's second expert, Dr. Skaletsky testified that he has not performed any surgeries since 2001, and that "the vast majority of patients who I see don't require surgery..." (P.X. 19, p. 7). Dr. Skaletsky did not examine the petitioner until more than four and a half years after the alleged January 23, 2005 accident. Dr. Skaletsky admitted during his deposition that the EMG study performed in 2003 would have been ordered to address preexisting radicular complaints, and also that the cervical MRI studies from 2003 and 2005 were essentially unchanged. (P.X. 19, p. 29). He agreed that there was no evidence of any cervical spine treatment for the period between petitioner's release from Dr. Pierre in March 2005, and the first consultation with Dr. Nockels in March 2008. (P.X. 19, p. 32). Dr. Skaletsky acknowledged that none of the doctors who treated petitioner's cervical injury prior to 2008 had ever recommended surgery. (P.X. 19, p. 33).

In support of the finding that Petitioner failed to establish that his current condition of ill-being is causally related to the injury, the Arbitrator notes the significant gap in treatment and time between the alleged January 23, 2005 date of accident, and the cervical fusion surgery that was performed in July 2008. The Commission has previously denied benefits based upon a lack of causal connection when there is a significant delay in receiving treatment or a significant gap in receiving treatment. *Gonzalez v. J. F. Daley International*, 99 IIC 3121. Similarly, in the case at bar, petitioner treated with Dr. Vernof, Dr. Alleva, and Dr. Pierre for his cervical injury between January and March, 2005, but none of those doctor recommended surgery, and he did not receive any treatment to his cervical spine whatsoever between March 2005 and March 2008. Petitioner was being treated for his unrelated heart issues, but there is no mention of any issues with his neck, arms, low back or other cervical symptoms.

The arbitrator finds that upon review of Dr. Gross's and Dr. Skaletsky's reports, neither opinion is sufficiently persuasive to establish causation. To the contrary, the Arbitrator relies on the medical opinions of Dr. Pierre and Dr. Alleva as well as that of Dr. Bernstein that the petitioner reached MMI back in April 2005, and that his need for the cervical fusion performed in 2008 is not causally related to the alleged January 23, 2005 work injury. Dr. Bernstein is a board certified orthopedic surgeon specializing in treatment of the spine. (Rx. 15, p. 12). He is also vice chairman of orthopedic surgery at Lutheran General Hospital and the director of spine trauma at Lutheran General Hospital. (Rx. 15, p. 12). Dr. Bernstein testified that he has performed approximately 2,000 cervical operations during his career. (Rx. 15, p. 13). Dr.

Bernstein testified that as part of his practice, he regularly reviewed diagnostic studies such as CT scans, x-rays, and MRI scans. (Rx. 15, p. 13). This is in contrast with Dr. Gross, who is not board certified in any areas and practices occupational medicine, and Dr. Skaletsky, who has not performed surgery since 2001.

Dr. Bernstein conducted a physical examination of the petitioner on April 15, 2005, less than three months after the alleged accident date. He found the petitioner had very good range of motion consistent with his age. No tenderness was noted, and petitioner demonstrated a completely normal neurological evaluation. (Rx. 15, p. 17). Dr. Bernstein further testified that based upon his review of the petitioner's history, his subjective complaints, the clinical findings of Dr. Bernstein's examination, and the medical records reviewed, that he felt petitioner had some degeneration in his neck, and that he likely suffered a cervical strain or temporary aggravation of the degenerative condition. (Rx. 15, p. 18). Dr. Bernstein felt that petitioner had a completely benign physical examination and that he was capable of performing unrestricted activity once his heart condition was resolved. (Rx. 15, p. 18).

Dr. Bernstein later had the opportunity to review diagnostic studies and films from both before and after the alleged date of accident. Dr. Bernstein testified that the MRI films showed no evidence of any acute herniation or tear. He testified that his diagnosis was a temporary aggravation of a degenerative condition or cervical strain. (R.X. 15, p. 43). He concluded that Petitioner's cervical surgery "has nothing to do with the accident whatsoever; and, furthermore, the surgery that was performed was performed for the intention of relieving cord compression, and not for the purposes of relieving neck pain." (R.X. 15, p. 44).

In addition to the petitioner having been determined to have reached MMI and being able to return to work with respect to his January 23, 2005, injuries, full duty without restrictions once his unrelated heart issues were resolved, there is evidence in the medical records that petitioner may have suffered a new injury during the treatment for his heart condition. Petitioner advised Dr. Noggels, while filling out the health history that:

> while undergoing a heart biopsy a few months ago the patient heard a "snap" in his neck and has had difficulty turning his head to the left ever since. The patient describes his pain as starting in the left side of his neck and radiating to the entire arm. The patient states he has pain in his left shoulder. (PX 15)

Based on the above, the arbitrator finds that the petitioner failed to prove that his alleged current condition of ill-being was causally related to the January 23, 2005, accident.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

Based on the arbitrator's findings above, the Arbitrator finds that the medical services provided after April 11, 2005, for treatment to the cervical spine, were not medically causally related to the alleged January 23, 2005, accident. Based on the foregoing findings and

conclusions, the issue concerning petitioner's claim for medical benefits is moot. Because the petitioner failed to prove a causal connection between the January 23, 2005 accident and his current condition of ill-being, he was not and is not entitled to receive any medical benefits for treatment after April 11, 2005 when he was determined to be at MMI.

The arbitrator further finds that in accordance with the Petitioner's evidence that his group medical carrier paid most of his medical bills, that the medical treatment was properly billed to the group carrier, as it was not necessitated by the accepted work injury on January 23, 2005.

In support of the Arbitrator's decision with regard to the amount due for temporary total disability, the Arbitrator makes the following conclusions of law:

For the reasons set forth above, the Arbitrator concludes that the petitioner is not entitled to any additional compensation for temporary total disability benefits, beyond the period from January 23, 2005, through April 15, 2005, a total of eleven and five sevenths weeks. Based upon the stipulations of the parties, the petitioner's rate of TTD should have been $448.72 per week. The petitioner should have received $5,256.43, in TTD payments. The petitioner stipulated that he received $4,991.91, in TTD payments leaving a balance of $264.52 owed to petitioner for underpayment of TTD.

Based on the foregoing findings and conclusions, the issue concerning petitioner's claim for temporary total disability benefits after April 15, 2005, is moot. The petitioner failed to prove a causal connection between his work injury and his alleged period of temporary total disability from the time he was released by his doctors for full duty work with respect to the injuries in March of 2005 and then found to be at MMI by Dr. Bernstein on April 15, 2005, through the present, and therefore, the issue of entitlement to TTD beyond April 15, 2005 is moot.

Petitioner testified that before he returned to work, he began experiencing heart problems that eventually resulted in an unrelated heart transplant. Accordingly, additional temporary total disability benefits pertaining to the January 23, 2005, date of injury are denied.

In support of the Arbitrator's decision with regard to the nature and extent of Petitioner's injury, the Arbitrator makes the following conclusions of law:

The records from Dr. Pierre and Dr. Alleva indicate that the petitioner was released to resume full duty work activities in March 2005, with respect to his work injuries from January 23, 2005. However petitioner was experiencing issues with his heart that were unrelated to the injuries sustained on January 23, 2005. Petitioner testified that before he returned to work, he began experiencing heart problems, which eventually resulted in a heart transplant.

Dr. Bernstein conducted a physical examination of the petitioner on April 15, 2005, and found the petitioner had very good range of motion consistent with his age. No tenderness was noted, and petitioner demonstrated a completely normal neurological evaluation. Dr. Bernstein,

based upon his review of the petitioner's history, his subjective complaints, the clinical findings of his examination, and the medical records reviewed, felt that petitioner had some degeneration in his neck, and that he likely suffered a cervical strain or temporary aggravation of the degenerative condition. According to Dr. Bernstein the petitioner had a completely benign physical examination and was capable of performing unrestricted activity once his heart condition resolved.

Based upon the foregoing discussion, the Arbitrator finds that Petitioner suffered 4% loss of use of a man as a whole as a result of the injury. Given the nature of the injury the Petitioner suffered he is entitled to have and receive from the Respondent compensation for 4% loss of use of the man as a whole, or **20** weeks at a weekly PPD rate of **$403.85** / per week.

In support of the Arbitrator's decision with respect to whether Respondent is entitled to credit pursuant to 8(j), the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the respondent is entitled to a credit for any and all outstanding medical bills paid as a result of the January 23, 2005, date of accident. Petitioner testified that a majority of his medical bills were paid through the group carrier, and evidence was presented indicating that a total of $101,316.95 was paid in medical expenses on the petitioner's behalf. To the extent any of those payments were made for medical treatment between January 23, 2005 and April 15, 2005, for treatment for petitioner's cervical injuries resulting from the January 23, 2005 accident, the respondent is entitled to a credit under Section 8(j) of the Act.

Respondent shall be given credit for $3,919.18 for medical benefits paid under Section 8(a) of the Act.

Respondent is entitled to credit for $4,991.91, in TTD payments as stipulated by the petitioner that he received. The testimony of Ms. McGill with respect to payments that were made was not clear with respect to the company that handled the account before she became involved with it.

The issue of whether or not petitioner has exceeded his choice of medical providers is moot due to the finding of the arbitrator that the petitioner's current condition of ill-being is not related to his work injury of January 23, 2005.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. For the foregoing reasons, respondent shall pay petitioner permanent partial disability benefits of **$403.85/week** for **20** weeks, because the injuries sustained caused the **4%** loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall be given a credit of **$5,207.16** for TTD, $**0.00** for TPD, and $**0.00** for maintenance benefits, for a total credit of $**$5,207.16**.

Respondent shall be given a credit of $101,316.95 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall be given credit for $3,919.18 for **medical** benefits paid under Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $448.72/week for 11 and 5/7 weeks, commencing 1/23/05 through 4/15/05, as provided in Section 8(b) of the Act. The respondent shall pay the petitioner $264.52 for outstanding TTD payments. The petitioner should have received $5,256.43, in TTD payments. The petitioner stipulated that he received $4,991.91, in TTD payments leaving a balance of $264.52 owed to petitioner for underpayment of TTD.

Deborah L. Simpson
Signature of Arbitrator

Jan 28, 2015
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Silvia Cordova,
Petitioner,

vs. NO: 14 WC 35816

Elite Staffing,
Respondent.

16IWCC0378

DECISION AND OPINION ON REVIEW

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

The Commission generally affirms and adopts the facts and conclusions determined by the Arbitrator in her Decision. However, the Arbitrator awarded TTD benefits from October 6, 2014 through April 6, 2015. The Petitioner did admit that she returned to work on October 13, 2014 and worked through October 23, 2014, when she first saw Dr. Jain, and ceased working thereafter (see transcript pp. 15, 19-20). Accordingly, TTD benefits for that period of time are denied. All else is affirmed and adopted.

16IWCC0378

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $252.73 per week for a period of 24-4/7 weeks, from October 6, 2014 through October 12, 2014, and from October 24, 2014 through April 6, 2015, those being the periods 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. The Respondent is granted credit for $2,307.36 for TTD payments made, as noted in the Arbitrator's Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $34,707.34 for medical expenses under §8(a) and within the confines of §8.2 of the Act. The Respondent is granted credit for $8,604.04 for medical expenses paid, as noted in the Arbitrator's Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the right shoulder surgery recommended by Dr. Schafer as delineated in the Arbitrator's Decision, as it appears reasonably necessary to cure or relieve the effects of the workplace injury as set forth in §8(a) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,100.00. 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: JUN 7 - 2016

Joshua D. Luskin

o-04/27/16
jdl/jl
68

Ruth W. White

Charles J. DeVriendt

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

CORDOVA, SILVIA
Employee/Petitioner

Case# **14WC035816**

ELITE STAFFING
Employer/Respondent

16IWCC0378

On 6/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0815 LUIS A ACEVES & ASSOCIATES PC
MIGUEL K PERRETTA
1931 N MILWAUKEE AVE
CHICAGO, IL 60647

5552 ELITE STAFFING
MARC CAIRO
1400 W HUBBARD ST SUITE 200
CHICAGO, IL 60642

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)

Silvia Cordova
Employee/Petitioner

v.

Elite Staffing
Employer/Respondent

16IWCC0378

Case # 14 WC 35816

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 Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **April 6, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0378

FINDINGS

On the date of accident, **10/4/14**, 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 $**18,955.44**; the average weekly wage was $**379.11**.

On the date of accident, Petitioner was **36** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**2,307.36** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**8,604.04** for other benefits, for a total credit of $**10,911.40**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$34,707.34**, as provided in Section 8(a), 8.2 and 8.2(a-3) of the Act. Respondent shall be given a credit of **$8,604.04** for medical benefits that have been paid.

Respondent shall authorize and pay for the treatment prescribed by Dr. Schaefer.

Respondent shall pay Petitioner temporary total disability benefits of **$252.73**/week for **26-1/7**th weeks, commencing 10/6/14 through 4/6/15, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$2,307.36** for temporary total disability benefits that have been paid.

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

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

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

Signature of Arbitrator

6-2-2015
Date

ICArbDec19(b)

JUN 2 - 2015

16IWCC0378

FINDINGS OF FACT

Silvia Cordova ("Petitioner") testified via Spanish interpreter that on 10/4/14, she worked for Elite Staffing ("Respondent") and had been so employed for the past 4 years. She described Respondent as a staffing agency that sends temporary workers to various locations. On 10/4/14 she worked for Respondent at the Ferrera candy company in shipping and receiving.

Her responsibilities included loading and unloading incoming and outgoing trucks, making and placing labels onto shipments. Petitioner testified that on 10/4/14, she worked for Respondent and was placing labels on a skid of pallets when another worker driving a forklift accidentally drove a skid of pallets into her, causing Petitioner to become pinned between the two stacks of pallets. She testified she felt an impact in the shoulder/arm, chest and neck and that her arm got stuck with the pallets. Petitioner described the pallets as taller than she. She felt pain all over especially in the right shoulder and arm. She said she reported to Fernando Navarro and that he completed an accident report that she signed. The report identified chest pain.

On 10/4/14, she presented to Rush emergency. Diagnosis was painful respiration and chest pain. Triage notes indicated that Petitioner was Spanish-speaking and that per her coworker she became pinned between two wooden pallets by a forklift at work. Petitioner reported pain with inspiration and expiration. Another emergency room note indicated that Petitioner reported being crushed momentarily between two pallets and forklift while at work and she complained of pain with deep breath. Dr. McCombs indicated that Petitioner had been crushed between two wooden pallets for 20 seconds by forklift while at work that evening. The accompanying translator indicated that Petitioner did not have her hands up at the time of the incident. Doctors noted that Petitioner's husband denied coughing up blood, numbness, tingling or any other injuries. CT of the chest identified possible small lung contusion. Chest x-rays were negative for fracture. Doctors diagnosed chest wall pain. Petitioner was directed to follow up with her primary care physician. She was prescribed Hydrocodone and discharged.

On 10/6/14, Petitioner returned to Rush emergency. Doctors noted she complained of chest and shoulder pain for the last 3 days. Petitioner complained of pain with deep breathing, pain all across her chest wall into both shoulders and arms. Doctors diagnosed chest contusion. Petitioner was released to return to work.

On 10/13/14, Petitioner presented to Occupational Health Centers of Illinois (OHCI) where she was evaluated by Gia Eliason, physician assistant. Chief complaint was noted to be chest pain following a 10/4 work injury where Petitioner was pushed and smashed against other pallets. Petitioner's height was noted to be 5'3". Petitioner described dull, constant thoracic pain 8 out of 10 in severity and dull, constant bilateral chest pain rated 5-6 out of 10. Petitioner explained that pain in both areas was exacerbated with lifting, pushing and pulling. Physical exam of the chest showed mild tenderness to palpation diffusely over bilateral anterior chest wall. Thoracic exam showed moderate tenderness to palpation at T2 through T8 with full range of motion. Pain with flexion, bilateral side bending and bilateral axial rotation were noted. The physician assistant assessed chest wall contusion, chest wall strain, contusion of the thorax and thoracic strain. Petitioner was prescribed therapy to address decreased range of motion,

medications, and light duty.

On that same date, Petitioner began physical therapy at OHCI. Initial evaluation noted chief complaint of pain in the right anterior chest, right posterior lateral shoulder and upper to mid back. Exacerbating factors included lifting the right arm, reaching and touching the shoulder. Alleviating factors were none. Therapists noted no prior history or injuries or impairments to the affected areas. Petitioner rated her pain 10 out of 10. Exam for active range of motion of the right shoulders showed flexion at 150°, abduction at 100°, pain in the posterior shoulder. Passive range of motion for the right shoulder showed flexion at 165°, abduction at 135°, both guarded. Palpation exam showed hypersensitive to touch on the right upper thoracic, to the right posterior shoulder, the clavicle, pectorals and right greater than left thoracic spinal paraspinals. Therapist assessed that Petitioner's exam was consistent with the medical diagnoses of shoulder/thoracic strain and chest wall contusion.

On 10/15/14, Petitioner attended therapy at OHCI. She continued reporting pain in the back of the shoulder and upper back but felt slightly better. Reaching was noted to be painful, shoulder abduction increased only slightly, and the pain was reported slightly less than prior visits. On that same date, Petitioner followed up with Dr. Eliason physician assistant. Through a translator, Petitioner reported that the pattern of symptoms was improving in both areas but slightly. She rated her chest wall pain 5 to 6 out of 10 in severity exacerbated with pressure to the area and with deep inspiration. Chest pain was alleviated with rest and shallow breathing. Pain in the back was rated seven out of 10 exacerbated with lifting, pushing, polling and alleviated with rest. Exam showed full range of motion bilaterally through the shoulders, normal grip and grip strength. Tenderness to palpation was noted at this thoracic level but she had full range of motion with flexion, extension, axial rotation and lateral flexion. Assessment was chest wall strain, contusion of the thorax and thoracic strain. Petitioner was prescribed medications, continued therapy and continued light duty.

On 10/20/14, Petitioner returned to therapy with OHCI. She reported slight improvement but with continued pain in the upper back and right upper thoracic region. Pain was rated 6 out of 10. Reaching was still noted to be painful, active range of motion in the shoulder was moderately improving.

On that same date, Petitioner returned to OHCI and saw physician assistant Gia Eliason for recheck thoracic and chest wall injury. Petitioner reported stabilizing symptoms but continued shortness of breath, thoracic pain 6-7 out of 10, exacerbated with lifting, twisting, pushing, pulling and alleviated with rest. Eliason performed a shoulder exam for range of motion bilaterally. Medications, therapies and light duty were continued. Petitioner testified at that time, she continued to experience right arm and shoulder pain and that she worked in pain.

On 10/23/14, Petitioner consulted with Dr. Neeraj Jain of Michigan Avenue Medical Associates. He noted Petitioner was injured when another worker moving a pallet hit her in the chest forcing her back into another pallet and had immediate chest, right shoulder and upper back pain. Petitioner complained of continued neck pain right greater than left and in the scapular area. She also reported radiating pain to the right arm, numbness and tingling to the right hand

and pain with overhead motion. She denied prior problems. Physical exam showed pain along the anterior glenohumeral joint, decreased range of motion, decreased grip strength in the right hand without motor or sensory deficits. Empty can, Neer's and Hawkin's tests were positive on the right. Dr. Jain ordered therapy, MRIs of the cervical spine and right shoulder and removed Petitioner from work. Diagnosis was right shoulder derangement, cervical facet syndrome, cervical discogenic pain and cervical radiculopathy all directly related to the injury. He based his opinions on the patient's history, her physical exam, imaging studies and medical records provided thus far.

On 10/23/14, Petitioner began her physical therapy with Premier Physical Therapy. The history noted was that Petitioner was working in the shipping department and was crushed between pellets and a forklift, striking the right side of her neck and shoulder. Petitioner's primary complaint at that time was right-sided neck pain and right shoulder pain along with occasional numbness in the right upper extremity to the fingertips. Therapist noted that there was increased pain with Petitioners current work. Pain was rated 7 out of 10 aggravated by standing, walking, using the right upper extremity and turning the neck. Therapy continued until approximately January 2015.

On 10/27/14, MRI of the cervical spine showed multilevel mild spondylotic changes and mild annular bulges. MRI of the right shoulder showed mild supraspinatus tendinosis with suspected partial thickness tearing along the bursal surface of the interior insertional fibers and trace fluid in the glenohumeral joint and subacromial subdeltoid bursa.

On 11/4/14, Petitioner complained to Dr. Jain of continued right-sided neck pain radiating into the arm, shoulder pain, decreased range of motion, inability to do any overhead motion and numbness and tingling in the right hand. Dr. Jain reviewed the MRIs and diagnosed right rotator cuff and cervical radiculopathy, cervical facet syndrome and cervical discogenic pain. Petitioner was referred to Dr. David Shafer for the right rotator cuff tear. Cervical epidural steroid injection was recommended to cervical pain and radicular symptoms indicated in physical exam. Petitioner remained off of work.

On 11/19/14, Dr. David Shafer evaluated the right shoulder. The doctor Petitioner's accident whereby she was crushed between two pallets following a forklift pinning her and that the shoulder was abducted and externally rotated when she was struck. Petitioner reported right shoulder pain 9 out of 10 points into the anterior and lateral aspect along with radiation up the neck and down toward the elbow laterally. She described it as constant and achy increasing at night. She also complained of popping, clicking, numbness and tingling to the forearm and hand, pain with overhead use and lifting. The doctor reviewed the MRI and diagnosed tendinosis of the rotator cuff with possible small grade partial thickness tearing and could not rule out labral tear. Assessment was rotator cuff tendinitis with possible labral tear. Dr. Schafer administered a cortisone injection. He opined that because Petitioner's right shoulder injury occurred while her shoulder was in an abducted and externally rotated position when she was struck she may have caused a labral injury in addition to the rotator cuff tendinitis. Light duty was ordered. Petitioner testified she obtained temporary relief from the injection.

On 11/26/14, Petitioner was evaluated at the request of the Respondent by Dr. Julie Wehner. Petitioner related she was injured when a forklift pushed a pallet hitting her right shoulder on the front on the pallet. Petitioner stated the pallet was 6 feet tall and she was standing sideways when she hit the front of her chest in her right shoulder. On exam, Dr. Wehner noted Petitioner was tender over the entire right arm with little tingling in the entire right arm. The doctor noted she lacked abduction on the right side of 10 to 20° where left was normal. Forward flexion was normal, abduction was normal and internal rotation was normal. Dr. Wehner reviewed pictures of the pallets with Petitioner, the accident injury report, emergency room records and recent treatment records. Dr. Wehner believed the right shoulder MRI findings were mild in nature and not consistent with an acute injury. She concluded that the findings of the cervical MRI were "within the realm of normal."

Dr. Wehner noted Petitioner began therapy at OHCI where she had full range of motion in her neck and shoulder but that when Petitioner began treatment with Dr. Jain "she then developed decreased shoulder range of motion and neck pain." The doctor concluded that the mechanism of injury was consistent with a chest contusion based on the mechanism of injury but present diagnosis was right shoulder and arm pain. The doctor noted nonspecific pain syndrome without a specific distribution and without any specific clinical findings as MRIs were normal. In support of this Dr. Wehner noted that Petitioner's clinical examination by the "occupational health physician was showing normal shoulder and neck range of motion" therefore it was unclear why "she would develop limited shoulder range of motion at a later date." The doctor stated that her present complaints about the shoulder and arm were not related or supported by the injury. Regarding the chest contusion the doctor concluded it had resolved, that Petitioner was not in need further treatment related to the injury, did not need restrictions and was otherwise at maximum medical improvement.

On 12/2/14 Petitioner followed up with Dr. Jain. Evoked potential testing of the upper extremities showed no delays. On 12/17/14, Petitioner followed up with Dr. Schafer and reported mild improvement of symptoms but with essentially unchanged complaints, symptoms and exam. He recommended continued conservative care to address right shoulder partial thickness rotator cuff tear. He opined that "the patient sustained an acute injury to the right shoulder secondary to this trauma. She has no history of pre-existing conditions to the right shoulder." Dr. Schafer reviewed Dr. Wehner's opinion that the MRI findings were not acute and noted that fluid in the region of the tear is consistent with an acute injury as there is no evidence of pre-existing pathology. He concluded the treatment was medically necessary to address her right shoulder condition and in order to return her back to work.

On 12/30/14, Dr. Jain discontinued Petitioner's neck therapy based on her plateauing and that most neck pain had subsided. He held any further recommendations for a cervical facet joint injection.

On 1/5/15, she testified she presented Respondent with Dr. Jain's light duty restrictions but that they were not accommodated. On 1/7/15, Dr. Wehner a second opinion report.

She noted that emergency room records made no mention of any direct blow to the shoulder, only that she was pinned between two crates for a few seconds and that Petitioner's hands were not up at the time of the impact. Dr. Wehner opined that the mechanism would not cause a rotator cuff tear and that the MRI findings were commonly found in an asymptomatic population not caused by this type of injury. She also concluded complaints of numbness and tingling in her hand along with decreased grip strength were not supported by radiographic findings.

On 1/14/15, Dr. Schafer noted unchanged symptoms, complaints and exam. Impingement signs were severely positive. He noted Petitioner's cuff tear failed to improve with conservative care and recommended surgery as causally related and medically necessary. On 2/25/15, Petitioner saw Dr. Schafer, whose recommendations and opinions were unchanged. He discharged her pending authorization.

On 3/25/15, Respondent's utilization review non-certified all physical therapy requested by Dr. Jain beyond the 10 initially approved. Dr. Alan Brecher indicated that the medical records available for his review or progress notes from Dr. Wehner and physical therapy notes from Premier thru January 2015 and miscellaneous information that was undated. The doctor based the non-certification on ODG guidelines allowing for a maximum of 10 therapy visits for shoulder strain.

Petitioner testified that prior the work injury, she has not felt similar pains before and had not been treating for the right shoulder. Prior to the work injury, she said she was able to work without restrictions. She testified she wishes to proceed with the right shoulder surgery. Since 1/5/15, Petitioner testified she has not returned to Ferrera or Elite Staffing for look for light duty work.

Fernando Navarro testified on behalf of Respondent. Regarding accidents, he stated that accidents involving workers they report to him. When one reports an injury, he determines whether the worker needs medical attention and completes an incident report. He is familiar with Petitioner and he was her supervisor. He said her job required heavy lifting sometimes by for example 25-30 pounds lifting a box onto a pallet but no higher than above his head. He recalled Petitioner suffered an accident but he did not witness it. He testified she told him she was fine and refused medical attention. After investigating, Navarro testified he asked Petitioner again and this time she looked like she was going to cry and stated she had chest pain with breathing.

Navarro was shown Rx1, which he identified as an accident/injury report in English. He did not know whether Petitioner speaks, reads or write English. He testified he completed the form using information given to him by Petitioner. He stated that under body part injured, he wrote "chest" because he recalled Petitioner stated she had pressure with breathing. He stated he did not leave any body parts out that she told him about. He said she signed it after he filled it out and after he explained the form to her. He recalled he took her to the emergency room and helped translate. He could not recall whether she complained of shoulder pain. Navarro stated

that Petitioner never presented any doctor note in January 2015 and February 2015. He could not recall whether anyone may have received any doctor note.

CONCLUSIONS OF LAW

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

The Arbitrator has carefully reviewed all medical evidence along with Petitioner's testimony and concludes the Petitioner has proven by preponderance of the evidence that her current conditions of ill-being as to the chest, right shoulder and cervical spine (neck) are all causally related to the undisputed 10/4/14 injury. In support thereof, the Arbitrator adopts and incorporates the findings of fact set forth herein as though fully set forth herein.

a. Chest

Petitioner credibly testified the work accident impacted her chest and chest contusion was documented in initial treatment records at both Rush and the company clinic, OHCI. Petitioner had no prior history of chest contusion and was otherwise in good health. Dr. Wehner believed Petitioner suffered a chest contusion in the accident. Therefore, under a chain of events theory, the Arbitrator concludes Petitioner's chest contusion is causally related to her work accident.

b. Right Shoulder

Respondent's doctor, Dr. Julie Wehner, concluded that Petitioner's right shoulder condition(s) were unrelated to her work injury because the mechanism of injury did not support such a finding and because Petitioner's medical records do not document any right shoulder problems until she began treating with Dr. Jain. Dr. Wehner indicated that she reviewed pictures of the pallets with Petitioner in describing her injuries. At no time did the doctor find or note Petitioner's description to be inconsistent with whatever photos were reviewed but concluded the mechanism did not support such an injury. Incidentally, the Arbitrator notes that no photos were ever submitted into evidence for review or consideration. Despite finding no discrepancies, the doctor relied on what she perceived to be delays in symptom reporting per Petitioner's treatment records.

However, the Arbitrator's analysis of the medical record supports a different conclusion. Petitioner testified the pallets were taller than her (she is 5 feet 3 inches) and that she became pinned between two pallet stacks while she was putting a label on top of the skid of pallets. She testified she was impacted in the chest, right shoulder/arm and neck areas. She testified she told Rush of shoulder, chest and neck pain. Navarro could not recall. In the Arbitrator's view, the initial 10/4/14 Rush emergency room record, on which Dr. Wehner heavily relied on in support of her opinion, contains conflicting statements that the Arbitrator declines to impute to the Petitioner. For example, various notes refer to Mr. Navarro as husband, as a co-worker and then later as simply a translator. In another example, it was documented Petitioner was pinned "momentarily," then for a "few seconds," and then as long as "20 seconds." In yet another example, emergency room records oddly document that Petitioner's "translator" indicated that

her arms or hands were not "up" at the time of the incident. Yet Petitioner's testimony was that she was putting labels on *top* of the skid of pallets. Evidence regarding her height, the height of the pallets, what she was doing at the time of the impact suggests to the Arbitrator that her right arm was elevated to some degree at the time of the accident. Further, Petitioner's testimony that she was putting labels on top is supported by and consistent with her report to Drs. Schafer and Wehner. Dr. Schafer wrote that her arm was abducted at the time of impact. Dr. Wehner noted she was putting labels on at the time of the impact. The fact that the position of her arms or hands were documented at all in the initial emergency room record indicates to the Arbitrator that Petitioner was truthful and credible that she had complained of right arm or shoulder pain, thereby eliciting questions in that regard and thereby documenting a response. Given the various examples of errors in the initial emergency room record, the Arbitrator believes Petitioner did in fact tell Rush of arm or shoulder pain and that it was incorrectly documented.

Less than 48 hours later, on 10/6/14, Petitioner returned to Rush complaining of *chest and shoulder pains for the past 3 days*. She complained of pain "all across her chest wall into both shoulders and arms." Physical exam of the chest, neck and shoulders were performed. In the Arbitrator's view, the notation indicates Petitioner had in fact complained of shoulder pain from the outset.

Further in support of the Arbitrators conclusion that Petitioner's right shoulder is causally connected to her work injury, on 10/13/14, Petitioner presented to the company clinic, OHCI. It should be noted that Petitioner was never seen or evaluated by any medical doctor there. Rather Petitioner was seen by Gia Eliason identified as a physician assistant. Dr. Wehner relies on the opinions of Ms. Eliason in support of her conclusion that Petitioner's right shoulder is unrelated. Dr. Wehner stated that Petitioner "developed decreased shoulder range of motion and neck pain" only after treating with Dr. Jain. The doctor apparently based this conclusion on the fact that she believed Petitioner had "full range of motion of her neck and shoulder" at the initial consultation with physician assistant Gia Eliason at OHCI.

However a closer exam of the 10/13/14 OHCI record shows that Gia Eliason performed physical exam of the cervical, thoracic and lumbar areas only, showing, in relevant part, full range of motion. There is no indication that the right shoulder was examined by Gia Eliason as Dr. Wehner suggests. The physician assistant went on to state that therapy was necessary "due to limited range of motion." From there, it is evident that therapy for the right shoulder was initiated per the physician assistant's recommendations. The 10/13/14 physical therapy record from the same facility, seemingly ignored by Dr. Wehner, clearly documented Petitioner's complaints located in the right anterior chest and the right posterolateral shoulder. Therapists also noted exacerbating factors of lifting the arm, reaching and touching the shoulder, 10 out of 10 shoulder pain and decreased active and passive range of motions at flexion and abduction.

In the Arbitrator's opinion, Dr. Wehner's understanding of this record is incorrect and her reliance on the physician assistant's assessment in misplaced. Therefore the Arbitrator declines to adopt the conclusions of Dr. Wehner and the view that Petitioner failed to timely complain of right shoulder symptoms as belied by Petitioner's credible testimony, the emergency room records and 10/13/14 OHCI records. The Arbitrator does not view less than 48 hours in

documented right shoulder complaints as unreasonable or fatal to Petitioner's claims especially given Petitioner's testimony that she did complain of shoulder pain at the initial emergency room visit. As for the accident report, testimony showed it was unknown whether Petitioner could speak, read or write English and Navarro could not recall whether Petitioner complained of shoulder pain. Navarro believed he did not leave anything out. In the Arbitrator's view, the accident report and any omissions thereto are outweighed by the other evidence, outlined above.

In addressing whether Petitioner actually has the presence of any significant pathology about the right shoulder attributable to the accident in question, the Arbitrator relies on and adopts the medical records and opinions of Drs. Jain and Schafer, both of whom interpreted the right shoulder MRI findings as significant for right shoulder partial rotator cuff tear. Dr. Schafer could not rule out a labral tear. Dr. Wehner's conclusion that the MRI was normal and shows pathology common in an asymptomatic population is not supported by the medical evidence. Dr. Schafer noted that MRI findings were acute in nature. The Arbitrator resolves the conflicting readings in favor of Petitioner. This conclusion is supported by Petitioner's medical history and her own testimony that prior to the undisputed accident, she had no problems, symptoms or injuries to the right shoulder. Thus, even if the Arbitrator adopted Dr. Wehner's conclusion that Petitioner's MRI findings are common in an asymptomatic population, the medical evidence shows Petitioner became symptomatic following her work accident, which would make Petitioner's right shoulder condition causally related under an aggravation analysis. However, the Arbitrator declines to adopt the opinions of Dr. Wehner and instead adopts the opinions of Dr. Schafer, who opined a causal connection between Petitioner's mechanism of injury and the right shoulder pathology.

Based on the foregoing, the Arbitrator concludes Petitioner's right shoulder is causally related to her work injury occurring 10/4/14.

c. Cervical / Neck

Petitioner testified she felt pain in her neck immediately following her work accident. Petitioner's complaints about the neck are timely, consistent and supported by the emergency room record, the initial record from OHCI, therapy notes from OHCI and the medical records from Dr. Jain. Petitioner was initially diagnosed with cervical sprain/strain following the accident. Petitioner presented to Dr. Jain with complaints of right-sided neck radiating to the right arm and right hand numbness and tingling. She denied similar or past problems. Based on clinical presentation, Dr. Jain diagnosed cervical discogenic pain, radiculopathy and facet syndrome causally related to the work accident. For the same reasons set for above, the Arbitrator declines to adopt Dr. Wehner's opinion that Petitioner's cervical sprain/strain is not causally related to the work injury. However, the Arbitrator does note that Petitioner's current and available medical records are consistent with a cervical (neck) sprain/strain. Although Dr. Jain believed Petitioner suffered from cervical radiculopathy, discogenic pain and facet arthropathy, the medical records, including the MRI of the cervical spine showing minimal disc bulging, most supports a causal relationship between a cervical sprain/strain and the work accident. In addition, Dr. Jain noted that Petitioner's neck pain appeared to have subsided as recent as December 2014. The doctor did indicate that if her symptoms returned or worsened

that she may be a candidate for further cervical spine treatment but the Arbitrator declines to speculate what that may look like in the future. Thus, based on the foregoing, the Arbitrator concludes Petitioner's cervical sprain/strain is casually related to her work accident.

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

Having found in favor of Petitioner on the issue of causal connection, the Arbitrator finds that Respondent has not yet paid for all reasonable and necessary medical services. The Arbitrator further finds that all bills as submitted by Petitioner contain substantially all the required data elements necessary to adjudicate those bills.

Regarding the medical treatment rendered by Rush University emergency room, Respondent advanced no reason why payment is not due and owing. Dr. Wehner's opinion suggests that, at the very least, the emergency room treatment was reasonable and necessary. Drs. Jain and Schafer opined all treatment had been reasonable and necessary. Therefore, Respondent shall pay directly to Petitioner reasonable and necessary medical services of Rush University in the amount of $7,916.26, Rush University Medical Group in the amount of $39.00 and University Pathologists in the amount of $50.60, as provided in Sections 8(a) and 8.2 of the Act. Respondent is entitled to credit for any amounts already paid.

Regarding the medical treatment rendered by Occupational Health, the Arbitrator finds that all treatment was reasonable and necessary to treat, relieve or otherwise cure Petitioner of her injuries. Therefore, Respondent shall pay directly to Petitioner reasonable and necessary medical services of Occupational Health in the amount of $1,034.42, as provided in Sections 8(a) and 8.2 of the Act. Respondent is entitled to credit for any amounts already paid to Occupational Health.

Regarding the medical services provided by Michigan Avenue Medical Associates, the Arbitrator finds all treatment reasonable and necessary and relies on the medical records and the opinions of Drs. Jain and Schafer in so finding. Therefore, Respondent shall pay directly to Petitioner reasonable and necessary medical services of Michigan Avenue Medical Associates, as provided in Sections 8(a) and 8.2 of the Act. Respondent is entitled to credit for any amounts already paid.

Regarding the medical services provided by Premier Physical Therapy, the Arbitrator finds all physical therapy treatment prescribed by Drs. Jain and Schafer was reasonable and necessary to treat, cure or otherwise relieve Petitioner of her cervical and shoulder condition(s). Respondent's retroactive utilization review in March 2015 denied all but the first 10 sessions of physical therapy, relying on ODG guidelines that shoulder strains allow for 10 visits and that Petitioner should have been using a home exercise program. Retroactive utilization review requires that the reviewer based reviews solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided. 820 ILCS 305/8.7(e)(2). Here, utilization review relied on Dr. Wehner's opinions, which were not

progress notes or medical treatment notes but rather opinions rendered for the purpose of evaluation under Section 12. Further, there was no indication those medical opinions were available to Dr. Jain, whom utilization review identified as the requesting provider. Finally, the utilization review identified the body part in question as the neck however cited to ODG guidelines concerning treatment for a shoulder strain. In considering and weighing the utilization review along with all other medical evidence, Arbitrator does not find the conclusions and recommendations of the utilization review persuasive based on the above. In addition, the Arbitrator notes that the evidence has established the existence of tendonitis and partial thickness rotator cuff tear and to that end, the utilization review is based on a faulty diagnoses. Therefore, Respondent shall pay directly to Petitioner reasonable and necessary medical services of Premier Physical Therapy $12,140.00, as provided in Sections 8(a) and 8.2 of the Act. Respondent is entitled to credit for any amounts already paid.

Regarding the medical services provided by Skan National Radiology, the Arbitrator finds that such treatment was reasonable and necessary to treat and diagnose Petitioner for the cervical and right shoulder conditions. The medical evidence supports Dr. Jain's recommendation for such testing based on Petitioner's continued complaints, symptoms and pain. Therefore, Respondent shall pay directly to Petitioner reasonable and necessary medical services of Skan National Radiology in the amount of $3,250.00, as provided in Sections 8(a) and 8.2 of the Act. Respondent is entitled to credit for any amounts already paid.

Regarding the medical services provided by EQMD / Equity Medical Solutions, the Arbitrator finds such prescriptions reasonable and necessary to treat Petitioner for her injuries. Drs. Jain and Schafer, whose opinions have been adopted over those of Dr. Wehner, explained that such treatment was reasonable and necessary to treat Petitioner. This would also include medications for post-injury nausea and vomiting symptoms, which are a sequalae to the original work injury. Therefore, Respondent shall pay directly to Petitioner reasonable and necessary medical services of in the amount of $5,898.06, as provided in Sections 8(a), 8.2 and 8.2(a-3) of the Act. Respondent is entitled to credit for any amounts already paid.

Respondent shall be given credit for $8,604.04 for medical services already paid under Section 8(a) and 8.2 of the Act. See, Ax1, Rx6.

ISSUE (K), (O) ***Is Petitioner entitled to any prospective medical care?***

Having found in favor of Petitioner on the issue of causal connection, the Arbitrator concludes that Petitioner is entitled to prospective medical care under Section 8(a). In support thereof, the Arbitrator adopts and relies on the medical opinions of Drs. Jain and Schafer over those of Dr. Wehner. Regarding Petitioner's cervical condition, Dr. Jain initially noted that Petitioner was in need of cervical facet injections but later withheld that recommendation. Therefore, the Arbitrator will not award any prospective medical care for the cervical spine injury.

16IWCC0378

Regarding the right shoulder, Dr. Schafer opined that Petitioner had failed conservative care and was in need of surgical intervention to address the right shoulder partial thickness rotator cuff tear and rotator cuff tendonitis. The doctor further stated that such interventional treatment was causally related and necessary to treat Petitioner and return her to pre-injury work. The Arbitrator adopts these opinions as more persuasive than those of Dr. Wehner. Dr. Wehner's opinions on Petitioner's need for prospective medical care are based on a faulty diagnosis of chest sprain/strain. Dr. Wehner acknowledged the presence of a right shoulder tear and although she categorized this as minimal, the Arbitrator disagrees with the conclusion that Petitioner is not in need of further care. The medical evidence shows that Petitioner is symptomatic for the right shoulder tear and that conservative care has failed and therefore is in need right shoulder surgical intervention. The medical evidence supports the opinions of Dr. Schafer in this regard. Respondent shall pay for an authorize right shoulder surgery as recommended by Dr. Schafer as well as any medical treatment incidental thereto.

ISSUE (L) What temporary benefits are in dispute?

Having found in favor of Petitioner on the aforementioned disputed issues, the Arbitrator finds and concludes that Petitioner is entitled to temporary total disability benefits from 10/6/14 – 4/6/15 representing 26-1/7th weeks. Respondent shall pay Petitioner temporary total disability benefits of **$252.73**/week for **26-1/7th** weeks, commencing 10/6/14 through 4/6/15, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$2,307.36** for temporary total disability benefits that have been paid.

Maria S. Bocanegra, Arbitrator

6-2-2015
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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin R. Bathon,
Petitioner,

vs. NO: 14 WC 39435

State of Illinois,
Pinckneyville Correctional Center.
Respondent.

16IWCC0379

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 sole issue of nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, generally affirms and adopts the facts and findings adduced as expressed in the Decision of the Arbitrator but for the calculation of credit due; the Decision of the Arbitrator is attached hereto and made a part hereof.

The Arbitrator concluded that the claimant had demonstrated a present degree of disablement to the right leg to the extent of 32.5% pursuant to Section 8(e)12 of the Act. The Arbitrator further found the Respondent had established credit for a prior settlement in case 97 WC 57623 to the extent of 25% loss to the right leg which would be set aside from this award, pursuant to Section 8(e)17. The Commission concurs with and adopts these findings.

The Arbitrator calculated the net award to the claimant would be 19.875 weeks, being 69.875 weeks for the present disability of 32.5% loss to the leg, less 50 weeks for the prior settlement; at the time of that prior claim, the leg was based on a total value of 200 weeks rather than 215, so 25% of a leg would be worth 50 weeks.

16IWCC0379

Section 8(e)17 holds that "...permanent partial loss of use of any such member... shall be taken into consideration and deducted from any award for the subsequent injury." The Commission concludes that utilizing weeks of disability awarded as the offset, rather than percentage loss of the body part, creates a non-equivalent, "apples-to-oranges" comparison. The degree of prior disablement, if available, is a better measure of appropriate credit than weeks of disablement or the cash value of a prior award.

Accordingly, the Commission calculates the current amount due to the claimant as follows: 32.5% loss to the right leg under 8(e)12 for present disability, less 25% loss to the right leg for the prior award, resulting in a net disablement to the claimant of 7.5% loss to his right leg over and above his prior disablement. 7.5% loss to the leg under 8(e)12 is 16.125 weeks of disability (215 x .075 = 16.125). The respondent shall therefore pay the claimant $735.37 per week for 16.125 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as noted above, the Decision of the Arbitrator filed November 16, 2015, is otherwise 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.

DATED: JUN 7 - 2016

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-05/25/16
jdl/jl
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NOTICE OF ARBITRATOR DECISION

BATHON, KEVIN R
Employee/Petitioner

Case# **14WC039435**

PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

16IWCC0379

On 11/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2924 HARRIS & JONES LAW FIRM PC
DEVIN M JONES
15 N DIVISION ST
DuQUOIN, IL 62832

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

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

NOV 16 2015

RONALD A. DASCIA, 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

Kevin R. Bathon
Employee/Petitioner

v.

Pinckneyville Correctional Center
Employer/Respondent

Case # 14 WC 039435

Consolidated cases: N/A

16IWCC0379

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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **September 11, 2015**. By stipulation, the parties agree:

On the date of accident, **September 25, 2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$64,230.41**, and the average weekly wage was **$1,235.20**.

At the time of injury, Petitioner was **40** years of age, ***married*** with **1** dependent child.

Necessary medical services and temporary compensation benefits have been provided by Respondent. Respondent has agreed that it has or will pay the causally related medical bills directly to the medical providers per the medical fee schedule or PPO agreement, whichever is less and that Respondent shall receive credit for all medical bills previously paid by it or paid through its group medical plan for which credit is allowed under Section 8(j) of the Act.

Respondent shall be given a credit of $- for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $-. The parties agreed that Petitioner received extended benefits/full pay for any lost time.

KEVIN R. BATHON v. PINCKNEYVILLE CORRECTIONAL CENTER,
No. 14 WC 039435

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner was a 40 year old correctional officer on September 25, 2014. Petitioner testified that on September 25, 2014, he went to break up an inmate altercation and he had to stop one inmate and hold him against the wall. Petitioner testified that he felt a pop in his right knee when this happened and he had immediate pain.

On September 25, 2014, Petitioner presented to the Family Medical Center with complaints of right knee pain that began when he broke up an inmate altercation. (PX2) Stephen Priebe, P.A. prescribed Ibuprofen and ordered an x-ray of Petitioner's right knee. Petitioner was taken off work through October 1, 2014.

On September 25, 2014, Petitioner underwent an x-ray of his right knee. (PX3) The findings were of a negative right knee radiograph.

On October 10, 2014, Petitioner presented to Dr. Brian Daines with complaints of right knee pain 7/10. (PX5) Dr. Daines noted that Petitioner had been experiencing no limitations with his right knee before his accident. Petitioner advised he had tried Ibuprofen, ice, elevation with minimal to no relief of his symptoms. Dr. Daines recommended an MRI of Petitioner's right knee.

On November 11, 2014, Petitioner underwent an MRI of his right knee. (PX6) The impression was of: 1) proximal patellar tendinopathy, likely acute; 2) the ligaments and menisci were intact; 3) there was scarring through Hoffa's fat from prior surgery; and 4) mild to moderate chondromalacia of the patellofemoral joint, no cartilage defect was identified.

On November 19, 2014, Petitioner presented to Dr. Daines in follow-up. (PX5) Dr. Daines advised he planned to treat Petitioner non-operatively. Petitioner received a cortical steroid injection. Dr. Daines advised Petitioner to do physical therapy for quadriceps and hamstring strengthening. Petitioner was advised to follow up in six weeks.

On December 30, 2014, Petitioner again followed up with Dr. Daines. (PX5) Petitioner reported the injection provided minimal relief of his symptoms. Petitioner advised he still had to limit his activity due to knee pain. Dr. Daines noted Petitioner's right knee condition had not responded to physical therapy, nonsteroidal anti-inflammatories, or ice. Dr. Daines recommended hyaluronic acid injections. In the event the injections were not approved, surgery was discussed.

On January 21, 2015, Petitioner presented to Dr. Richard Hulsey for a Section 12 examination at Respondent's request. (RX6) Dr. Hulsey opined that if Petitioner had not had any recent problems with his knee prior to his accident, then he felt that the need for treatment

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 $735.37/week for 69.875 weeks, pursuant to Section 8(e) of the Act, because the injuries sustained by Petitioner resulted in 32.5% loss of use of the right leg. However, the parties agree that Petitioner received a prior settlement in case number 97 WC 57623 for 25% loss of use of the right leg. When that settlement was entered into the maximum number of weeks allowed for the loss of use of the leg was 200 weeks; therefore, 25% loss of use of the leg equated to 50 weeks The maximum number of weeks allowed for the loss of use of the leg on the date of this hearing was 215 weeks. Applying the credit from the previous award (in weeks), Respondent is ordered to pay Petitioner permanent partial disability benefits of $735.37/week for 19.875 weeks (69.875 weeks – 50 weeks credit from prior settlement).

Per the stipulation of the parties Respondent is ordered to pay all reasonable and causally related medical bills directly to the medical providers per the Illinois Medical Fee Schedule or PPO Agreement, whichever is less. Respondent shall receive a credit for all medical bills previously paid.

Respondent shall pay Petitioner compensation that has accrued from **September 25, 2014** through **September 11, 2015**, 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

November 9, 2015
Date

was directly based on his work injury. Dr. Hulsey recommended a diagnostic arthroscopy to treat Petitioner's right knee condition.

On February 13, 2015, Petitioner presented to Dr. Daines. (PX5) Petitioner reported continued pain in the medial aspect of his knee. Petitioner advised he wished to proceed with a right knee diagnostic arthroscopy and partial medial meniscectomy.

On March 4, 2015, Petitioner underwent an arthroscopic medial femoral condyle chondroplasty, anteromedial meniscal partial meniscectomy, patellofemoral chondroplasty, and debridement of anterior scarring of Hoffa fat pad performed by Dr. Daines. (PX4)

On March 18, 2015, Petitioner presented to Dr. Daines for follow-up. (PX5) Petitioner reported that he felt much better than he did before surgery. Dr. Daines advised Petitioner to continue working hard on his dynamic stabilizers, specifically his quadriceps and hamstrings. Dr. Daines advised Petitioner to return in four weeks.

Petitioner stopped attending therapy on April 20, 2015. At that time the therapist noted that Petitioner was tolerating high level strengthening exercises and had resumed functional activities at home. (PX 9)

On June 2, 2015, Petitioner followed up with Dr. Daines. (PX5) Petitioner advised he was doing his regular activities, but he occasionally had some popping in his knee and a little stiffness in the morning. On physical examination Petitioner had 0-130 degrees range of motion. No instability anteriorly to posteriorly, or varus or valgus stress was noted. Dr. Daines advised Petitioner he was doing well and was at maximum medical improvement. Petitioner was instructed to follow up on an as-needed basis.

Petitioner's case proceeded to arbitration on September 11, 2015. The sole issue was the nature and extent of Petitioner's injury. Petitioner testified that on September 25, 2014, he went to break up an inmate altercation and he had to stop one inmate and hold him against the wall. Petitioner testified that he felt a pop in his right knee when this happened and he had immediate pain.

Petitioner testified that his knee condition has definitely improved and he confirmed that he was released with no permanent restrictions. Petitioner testified to experiencing some ongoing symptoms depending upon the weather. For example, his right knee swells a little bit when it rains. Petitioner testified that his knee is a little stiffer and he has a little trouble sleeping because his knee throbs once in a while. Petitioner testified that his right knee is probably a little weaker, but he wouldn't say it was a tremendous amount.

Petitioner testified that his knee affects his hobby of coaching football because he can't kneel down on his knee, but he is still able to coach football.

Petitioner testified that he is currently assigned as a grounds keeper at work and notices he is slower when jumping on and off a tractor, but he is still able to do so. He doesn't stand on ladders for extended periods of time.

On cross-examination Petitioner testified that Dr. Daines advised him that he could continue to improve for up to one year after surgery.

Petitioner testified that he takes over-the-counter Ibuprofen when he experiences soreness or swelling in his knee.

Petitioner testified to a little stiffness and a little trouble sleeping due to occasional throbbing in his knee. He further testified that he doesn't notice a tremendous amount of weakness in his knee.

Petitioner testified that he has not seen Dr. Daines since June 2, 2015, but that he is supposed to see him again in six months.

On cross-examination Petitioner testified that he is currently temporarily assigned to the maintenance department, but he is still a correctional officer. Petitioner agreed that he makes the same pay as he did prior to his accident. Petitioner testified that he has been able to perform his job. Petitioner testified that he hopes his temporary assignment to maintenance becomes a permanent assignment. Petitioner was unaware of any complaints from his supervisor regarding the quality of his work.

Petitioner acknowledged that Dr. Daines told him he should continue to improve for up to a year after surgery. He still performs his home exercises.

Subsequent to the arbitration hearing Respondent's attorney discovered that Petitioner had a previous award of 25% loss of use of the right leg in case number 97 WC 057623. By agreement of the parties, the parties submitted an Agreed Motion to Reopen Proofs and Supplement the Record Instanter. A copy of the Agreed Motion has been marked as Arbitrator's Exhibit 5 and made a part of the record.

The Arbitrator concludes:

Since the accident occurred after September 1, 2011, Section 8.1(b) of the Act applies.

Pursuant to Section 8.1(b) of the Act, the Commission shall base its determination of permanent partial disability 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. 820 ILCS 305/8.1(b).

(i) Neither party submitted a rating pursuant to Section 8.1(a). Therefore, the Arbitrator gives no weight to this factor.

(ii) Occupation: Petitioner was employed as a correctional officer at Pinckneyville Correctional Center at the time of his accident. He testified that he is back to work

full duty. While he is temporarily assigned to a different job (maintenance) and hopes that the position becomes a permanent one, no evidence was presented that this temporary assignment stems from his injury or is less physical than that of a correctional officer. Petitioner did testify that he can perform all required duties albeit sometimes he is a little slower (as when getting on/off the tractor at work). The Arbitrator gives this factor some weight.

(iii) Age: Petitioner was 40 years old at the time of his injury. As such Petitioner can reasonably be expected to live and work with the effects of his work injury for a reasonable time into the future. Accordingly, the Arbitrator gives some weight to this factor.

(iv) Earning Capacity: There is no direct evidence of diminished future earning capacity in the record. In fact, Petitioner testified he is currently paid the same amount as he was prior to his accident. The Arbitrator gives no weight to this factor.

(v) Disability: Petitioner was a very credible witness. He did not try to exaggerate or embellish any ongoing complaints. He was candid in acknowledging that he is getting older and trying to balance any ongoing difficulties/symptoms with those one might associate with the aging process. He acknowledged that his condition has improved since the injury and that he is better since surgery. His ongoing complaints include swelling, difficulty kneeling, standing, and ladder climbing, and some stiffness and weakness. His testimony was generally corroborated by his treating records.

Having considered the foregoing factors, the Arbitrator concludes that Petitioner is now permanently partially disabled to the extent of 32.5 % loss of use of the right leg as provided in Section 8(e) of the Act.

The parties agree that Petitioner received a prior settlement in case number 97 WC 57623. That settlement was for 25% loss of use of the right leg. When that settlement was entered the maximum number of weeks allowed for the loss of use of the leg was 200 weeks; therefore, 25% loss of use of the leg equated to 50 weeks. The maximum number of weeks allowed for the loss of use of the leg on the date of this hearing was 215 weeks.

Applying the credit from the previous award, Respondent is ordered to pay Petitioner permanent partial disability benefits of $735.37/week for 19.875 weeks (69.875 weeks – 50 weeks credit from prior settlement).

****

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

Joaquin Banderas,

Petitioner,

vs.

NO: 14 WC 32465

Cermak Produce No. 11, Inc.,

Respondent,

16IWCC0380

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 temporary total disability, causal connection, medical, prospective medical, penalties, and any and all other issues raised during the hearing and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 10, 2015 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.

16IWCC0380

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1.00. 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: JUN 8 - 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:5/19/16
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

BANDERAS, JOAQUIN
Employee/Petitioner

Case# **14WC032465**

16IWCC0380

CERMAK PRODUCE NO 11 INC
Employer/Respondent

On 11/10/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2461 NYHAN BAMBRICK KINZIE & LOWRY
GARY WALLACE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

16IWCC0380

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)

JOAQUIN BANDERAS,
Employee/Petitioner
v.

Case # **14 WC 32465**

CERMAK PRODUCE NO. 11, INC,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **August 27, 2015 and August 28, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS
On the date of accident, **July 23, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,263.16**; the average weekly wage was **$485.83**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$4,525.71** for TTD, $N/A for TPD, $N/A for maintenance, and **$2,500.00** for other benefits, for a total credit of **$7,025.71**.

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 **$323.89**/week for **5 4/7^{ths}** weeks, commencing **July 23, 2014** through **September 1, 2014**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$4,525.71** for TTD and **$2,500.00** for other benefits, for a total credit of **$7,025.71** that have been paid.

Petitioner's claims for any medical treatment after September 1, 2014, Petitioner's claims for any temporary total disability benefits after September 1, 2014, and Petitioner's claims for penalties and attorneys' fees are denied, because Petitioner's current condition of ill-being is not causally related to the injury.

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

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

Milton Black

Signature of Arbitrator

November 8, 2015

Date

ICArbDec19(b)

NOV 10 2015

FACTS

Petitioner suffered an accident arising out of and in the course of his employment with Respondent on July 23, 2014. Petitioner was cleaning a cooler. While moving containers of meat, he injured his lower back. Initial medical treatment was at St. Anthony Occupational Medicine for a lumbar strain (PX1, p6). An MRI dated August 5, 2014 indicated mild degenerative disc disease (PX1, p3). Petitioner was treated with medication, given work restrictions, and physical therapy was ordered (PX1, pp6-9).

Petitioner testified on direct examination that when he was discharged from St. Anthony Occupational Medicine on August 29, 2014, he was told he needed to see another doctor. On cross-examination, Petitioner admitted that he was told he needed to see another doctor for osteoarthritis and that his condition was no longer related to his work accident. The cross-examination version is corroborated by the August 29, 2014 St. Anthony Occupational Medicine chart note of (PX1, p22).

Petitioner testified that he next went to Marquis Medicos for further treatment. Those records indicate Petitioner received multiple chiropractic treatments as well as multiple physical therapy sessions from September 2, 2014 through January 14, 2015 (PX2). Petitioner testified that he was referred to Dr. Harsoor, a pain specialist, by the Marquis Medicos Group, for further pain management. Petitioner testified that he was referred to Dr. Erickson (PX6) for a surgical consult by Dr. Harsoor.

On October 16, 2014, Petitioner was evaluated by Dr. Gunnar Andersson, an orthopedic surgeon at Midwest Orthopedics. Dr. Andersson examined Petitioner and reviewed medical records. Dr. Andersson stated that there was an essentially normal MRI. Dr. Andersson concluded that all treatment through August 29, 2014 was reasonable and necessary. Dr. Andersson further concluded that treatment beyond August 29, 2014 was not related to the accident of July 23, 2014. Dr. Andersson further concluded that Petitioner had reached maximum medical improvement as of August 29, 2014 (RX1). August 29, 2014 was the Friday before Labor Day.

DISCUSSION

The Arbitrator finds that Petitioner's current condition of ill-being is not related to the accident of July 23, 2014. The Arbitrator specifically adopts the opinions of Dr. Gunnar Andersson and of Dr. Carl Gustas.

Therefore, the Arbitrator makes the following findings:

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

Petitioner's claims for any medical treatment after Labor Day, September 1, 2014 are denied.

Petitioner's claims for any temporary total disability benefits after September 1, 2014 are denied.

Petitioner's claims for penalties and attorneys' fees are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sheryl Faust,
Petitioner,

vs.

NO: 12 WC 39900

16IWCC0381

Cadence Health,
Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission finds that in addition to the analysis performed by the Arbitrator, there is a need to address whether Petitioner's alleged excessive standing and bending superimposed on Petitioner's acknowledged pre-existing degenerative condition was sufficient to prove that her work duties were "a" cause of her current condition of ill-being.

As the Arbitrator indicated in her decision Petitioner initially signed an Application for Adjustment of claim on November 2, 2012 in which she alleged an accident date of July 1, 2011. Petitioner then at the start of the arbitration hearing amended her Application for Adjustment of Claim alleging an accident date of September 1, 2011. The Commission finds that while Petitioner's attorney is correct in stating that they have a right to amend an Application of Adjustment of Claim at any time prior to and during the Arbitration hearing, conversely Respondent has a right to point out that Petitioner did at one point claim an earlier manifestation

date with a different theory of the claim ie. excessive sitting than was ultimately presented ie: excessive standing/bending and furthermore has the right to place Petitioner's credibility at issue.

Currently before the Commission is Petitioner's amended claim with an alleged September 1, 2011 manifestation date. Petitioner is claiming that she had to stand up/bend over up to 12 hours a day and this caused her low back to be symptomatic. The Commission notes that when Petitioner was asked to produce a schedule showing her work hours and how often she performed her work duties 12 hours a day Petitioner responded that she would have to look at the training schedule which she does not have in front of her but which is in the records. When she was asked to estimate how many 12 hour shifts she was assigned, Petitioner again said she would have to look at the record. She further stated it was a long time ago and without looking at the training schedule she could not give an estimate of how many days a week she was assigned the 12 hour shift. While Petitioner further testified that she was bent over 60% of the time, again, Petitioner could not recall how may days she was placed in this position. What Petitioner did testify to was that there were two trainers in the room. One trainer was in front and one trainer in the back of the room. Petitioner never provided any evidence in terms of the ratio of how often she was the primary trainer in front of the room and how often she was the secondary trainer in back of the room. At most, she again testified that she could not recall and the records would indicate whether she was the primary or secondary trainer.

Ms. Wagner, the principle trainer for the program, testified that during the demonstration portion of Petitioner's job the typical hours for trainers spanned from 8 a.m. to 4:30 p.m. and a typical work day was 8 hours long and took place between Monday and Friday with a break for lunch. Ms. Wagner testified that the trainer was either assigned two 4 hour classes back to back with breaks in between or worked a split shift where the trainer worked in the morning and then worked again in the evening with down time in between in the afternoon. While Petitioner claims she was scheduled for 12 hour shifts and she submitted PX1, an e-mail to that effect, Ms. Wagner said she was not aware of Petitioner being scheduled for 12 hours straight. She said there were breaks of at least a 1/2 an hour between the 4 hour sessions. Ms. Wagner further indicated that per Petitioner's request chairs were brought in and the two trainers divvied up what role they performed in the training sessions. Furthermore, the CHD job description entered as Respondent's RX5 said Epic trainers would sit 0-35% of the day and stand 36-55% of the day.

While Dr. Popp expressed a positive causal connection opinion that increased standing and bending forward placed stress on Petitioner's back, he replied as such to Petitioner's attorney's hypothetical containing unsubstantiated facts that Petitioner was forced to do 8-12 hour shifts over a two month period during which she was on her feet 50% of the time and was bending over 50% of the time. Conversely, Dr. Levin, opined that there was no aggravation referable to the lumbar spine from Petitioner's work in August/September of 2011. Given the evidence submitted as a whole, the Commission finds that Petitioner both failed to provide evidence, other than her own testimony, that there is a sufficient basis in which they can conclude that Petitioner's activities of standing and bending were excessive and as a result Petitioner's pre-existing low back condition was aggravated by her work duties.

In terms of the mechanics of the injury itself, the Commission questions whether Petitioner's sitting, standing and bending were part and parcel of Petitioner's work activities such that they subjected her to greater harm than a member of the general public. The Commission finds that sitting, standing and bending are activities of daily living that are performed equally by workers and non-workers alike and that are performed in all aspects of a daily living. As such the question became one of whether or not these activities were required to be performed in an excessive manner in which Respondent subjected Petitioner to a greater harm of injury than a member of the general public. As indicated above, the Commission does not believe Petitioner provided sufficient evidence to support that her work duties and specifically her alleged excessive standing and bending subjected her to a greater harm of injury than a member of the general public. Thus, the Commission finds that Petitioner's claim is not substantiated by the evidence contained in the record and as such is not compensable under the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove she sustained any accidental injury as a result of the September 1, 2011 accident her claim for compensation is hereby denied.

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

DATED: JUN 8 - 2016

MB/jm

O: 5/19/16

43

Mario Basurto

David L. Gore

Stephen Mathis

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

FAUST, SHERYL
Employee/Petitioner

Case# **12WC039900**

16IWCC0381

CADENCE HEALTH
Employer/Respondent

On 10/26/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1869 PRESBREY & ASSOC LLC
KURT NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

0075 POWER & CRONIN LTD
ELENA CINCIONE
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

FINDINGS

On the date of accident, **9/1/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**70,000.00**; the average weekly wage was $**1,346.15**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **0** dependent children.

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

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

Respondent is entitled to a credit of $**21,160.68** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner failed to establish that the sustained a compensable work accident.

All other issues are rendered moot and all requested compensation and benefits are denied.

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

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

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

Signature of Arbitrator

10/20/15
Date

ICArbDec19(b)

OCT 26 2015

A: I was in pain....Because I was sitting so much I was in increasing pain. Lumbar pain was intense going down my legs. Cervical pain that I had never experienced before was the new pain that I had as a result of the sitting. But I also had lumbar pain from being in one position for an extended period of time. (T. 17-18)

The second phase of the EPIC job began the last week of August, 2011. (T. 17) required Petitioner to train groups of physicians on the use of the EPIC software program in an auditorium, classroom setting. (T. 17) Each training session had two trainers: the lead trainer stood at a podium in front of the class while the secondary trainer walked around the classroom assisting physicians who with the database. (T.21-23) Petitioner testified that she spent six days per week performing the secondary trainer role which required her to bend over in a "fulcrum position" to assist the seated physicians on the database. (T. 24) She estimated that 60% or more of her time as the secondary trainer was spent in this position. (Id.)

Petitioner testified that the trainers were not allowed breaks during a training session (which lasted four to six hours) nor were the trainers allowed to sit in chairs. (T.25) This phase of the EPIC job lasted for 8 weeks. She worked anywhere from four to twelve hour days, 6 days a week. (T.22, 25, 31)

Petitioner testified to experiencing agonizing pain during this period of time at work:

> *I could not feel my legs because I was never sitting, I was always standing. So I had the continued – I had numbness and radiating pain down my legs when I would be the person standing. When I was the trainer who was assigned second position in the back, bending I would have searing pain in my lumbar region to the point I was reduced to tears.* (T. 26)

On direct exam, Petitioner testified that she had prior low back pain involving "an impingement" at L5-S1 resulting from a biking incident two years prior to the alleged injury manifestation date. She was treated with "a spinal injection" which, according to her, was "well treated". Petitioner further testified that she was "just fine" as long as she was "moving and doing the normal things" she did in her job prior to the Epic position. (T. 20) Petitioner testified that her job prior to the Epic position did not require sitting for entire shifts. (Id.).

When questioned on cross-exam about her prior back condition, Petitioner testified that she had "couple injections" prior to July 2011. (T. 64).

Respondent's Exhibit 1 is Petitioner's original Application for Adjustment of Claim. Petitioner testified on cross that the date of accident is July 1, 2011 and that she signed the document.

Petitioner testified that she sought initial care at the Delnor pain clinic with her primary care physician, Dr. Cladis who instituted work restrictions of no standing for more than four hours which was accommodated by Respondent. (T. 31-32)

Respondent eventually terminated Petitioner in January of 2013 after Petitioner's work was further restricted by Dr. Cladis. (T. 32-33)

On cross, Ms. Wagner testified that it was Petitioner who requested that chairs be furnished for the trainers.

Medical Records Prior to the Alleged Injury Manifestation Date

On May 31, 2006, Petitioner was examined by a physicians' assistant, reporting that she felt sharp pain in right hip and felt something "pop" three days after the car accident. She reported pain running down the hip and leg and the PA identified bruises on the bilateral hip area. Exam of the back was normal and the hips showed no weakness and a full range of motion. A "hip flexor strain" was the assessment. (RX 5)

On June 18, 2007, Petitioner underwent a DEXA scan at Delnor Community Hospital which revealed osteopenia in Petitioner's hip and lumbar spine. (Id.).

On September 9, 2009, Petitioner underwent another DEXA scan. (Id.) Petitioner was diagnosed with osteopenia of the lumbar spine and bilateral femoral necks. (RX 5).
On June 16, 2010, Petitioner presented to Dr. Cladis at Greater Valley Medicine (Internal Medicine and Chiropractic) with complaints of intermittent hip pain, radiating into the buttock that began one month ago. Petitioner was diagnosed with pirformis syndrome. Various chiropractic manipulations were performed. (Id.)

On June 26, 2010, Petitioner presented to Delnor hospital with a history of left glute pain for the last month after riding her bicycle for approximately 20 miles in Wisconsin. Petitioner reported consulting with her family doctor within a couple of days after the biking episode who gave her a Medrol Dosepack. (RX5) Petitioner reported treating with a chiropractor approximately two weeks ago who administered various forms of treatment that helped for a limited time. (Id.) Petitioner reported increasing pain in her buttocks over the past 2-3 days that caused difficulty walking. Petitioner reported radiation of pain to the anterior aspect of her left thigh since the initial onset of pain. (Id.) Petitioner was diagnosed with sciatica and left buttock/low back pain and prescribed Toradol 60 mg and Norco 10mg.

On June 30, 2010, Petitioner underwent a lumbar MRI at Delnor Community Hospital. (RX 4) The MRI report noted a history of left buttock pain. The MRI findings note the following:

1. Degenerative disk changes at L1-L2 through L5-S1, most significant at L3-L4, L4-L5 and L5-S1;

2. A right sided L5-S1 herniated nucleus pulposus abutted and displaced the right S1 nerve root;

3. The L4-L5 level had bilateral facet arthritis with some foraminal stenosis bilaterally and degenerative disk changes;

4. The L3-L4 level had right greater than left facet arthritis, lateral recess stenosis, foraminal stenosis on a bony basis and degenerative disk changes.

Her lumbosacral spine exhibited no tenderness on palpitation and her left sided straight leg raise was negative. Dr. Cladis noted that her sciatica was worse. The doctor placed work restrictions of standing no more than four hours a day and no repetitive bending, lifting or twisting. He also recommended therapy but noted that her work schedule would not accommodate the therapy. Petitioner was instructed to do home exercises. Another epidural steroid injection was ordered. (Id.)>

On September 15, 2011, a physical therapy evaluation summary noted that Petitioner "is a 57-year-old female referred with a diagnosis of sciatica/degenerative disc disease. Symptoms initially began in June, 2010 however have worsened in the past 2 months. Patient was in a motor vehicle accident in June, 2010 at which time she had left hip/low back involvement with pinching- type sensation. MRI showed L5-S1 involvement with impingement. Patient also had a nerve conduction velocity test and radiofrequency test. Last evening at work during an Epic presentation at CDH on 9/14/11, patient tripped over exposed cords and lurched forward which exasperated her symptoms". (RX5) Petitioner was prescribed physical therapy twice weekly for 6 weeks. (Id.)

Petitioner underwent a right hip MRI on August 15, 2012, which demonstrated findings consistent with right greater trochanteric bursitis with partial tear of insertion of the right gluteus minimus tendon.

On October 4, 2012, Petitioner presented to Dr. Cladis, with low back pain complaints which were noted to have become more chronic due to the physical demands of her job. (PX4) Petitioner reported her pain as constant and aggravated by 12 hour days at work. She reported severe low back spasms/right hip pain since January of 2012 with constant standing and walking during the "go live" process for the EPIC program. Petitioner noted an improvement in her pain when she did a sedentary job with less standing. On exam, her lumbar spine was tender to palpation and she had lumbar pain and right sciatic notch pain. She also exhibited spasms of the bilateral lumbar paraspinal muscles. A straight leg raise test on the right was positive at 45 degrees and the left side remained negative. The diagnoses at that time included bursitis of the right hip, lumbago, intervertebral disk degeneration, herniated intervertebral disk and sciatica. Dr. Cladis recommended that she reduce physical therapy and that she use 10 mg of Flexeril three times a day. She was also restricted to sedentary activity at work, with limited standing, limited walking, and five hour days. Dr. Cladis further restricted her to sit down jobs and limited her walking and standing to 30 minutes per shift.

Petitioner consulted with Dr. Craig Popp on April 4, 2013. (PX2) Dr. Popp ordered flexion/extension lumbar X-rays on that date that showed grade 1 degenerative spondylolisthesis at L4-L5 and degenerative disk changes at L3-L4. The films also revealed anterior 5 mm of slippage between the posterior aspect of the L4 vertebral body and the posterior aspect of the L5 vertebral body.

On April 7, 2013, a lumbar spine MRI showed advanced degenerative facet joint changes with areas of synovial cysts formation posterior to the thecal sac at L4 level, likely related to the advanced degenerative facet joint changes at the L4-L5 level with degenerative changes also noted at L3-L4. (PX4)

Even so, Dr. Popp thought the surgery would provide good pain relief to Petitioner. (PX1 p.12)

Dr. Popp testified that in the event that Petitioner did not receive the fusion, her condition would continue to degenerate and she would probably be limited to sedentary work. (PX1 p.12)

Dr. Popp noted that Petitioner's job required her to spend a significant amount of time bending forward in an awkward position looking over people who were learning the EPIC program. (PX1 p.13) Spondylolisthesis is a condition where one vertebral level is already shifting in front of the next level, and bending forward creates an increased shear force across the two vertebral bodies. (PX1 p.14) Dr. Popp opined that Petitioner's training activity exacerbated this pre-existing condition. (PX1 p.14) He testified that the change in Petitioner's work activity levels was related to the onset of the pain which he was treating. (PX1 p.20) Dr. Popp was personally familiar with Petitioner's pre-EPIC work activities through his own observation and her description of the duties. (PX1 p.20-21) Dr. Popp noted that he had been documenting in his notes that Petitioner's condition was work related throughout the treatment. (PX1 p.22) Dr. Popp also referenced a July 21, 2014 note from Dr. Siodlarz who had been managing Petitioner's pain. (PX1 p.22-23) Dr. Siodlarz similarly reported that Petitioner was experiencing low back pain due to repetitive work injury. (PX1 p.23-24) Dr. Popp agreed with that assessment, noting that Petitioner's pre-existing low back conditions became aggravated by the change in her work activities. (PX1 p.24)

Dr. Popp testified a synovial cyst in the spine is a sign of degeneration in the spine. (PX 1, p. 44-45). Additionally, he testified that he based his conclusions as to the cause of her back pain on statements made by the Petitioner and not any observations of her work activities, specifically Petitioner's statement that she was asymptomatic prior to working as an EPIC trainer. (PX 1, p. 48, 52).

On cross-examination, counsel for Respondent challenged Dr. Popp on Petitioner's pre-accident treatment history. Dr. Popp noted that he was aware that Dr. Morowski had treated her previously for low back pain and some leg pain with epidural steroid injections from Siodlarz. (PX1 p.26) Respondent asked whether Petitioner told him about a car accident from 2006, her DEXA scan results, osteopenia, a nonspecific autoimmune connective tissue condition, arthritis, sciatica, osteoarthritis, Reynaud's disease or the lumbar MRI spine from 2010. Dr. Popp noted that none of the comorbidities which Respondent asked him about changed his opinion on causation. (PX1 p.51-52) The Reynaud's was a circulatory condition which had nothing to do with her condition. (PX1 p.36) The MRI images between 2010 and 2014 revealed a worsening of Petitioner's condition during the interim, supporting the idea that Petitioner injured herself with the EPIC work. The 2014 lumbar MRI showed a worsening of Petitioner's condition from the 2010 MRI, with the later MRI revealing a pseudo-disc protrusion at L4-5 superimposed upon and slightly displacing the right neuroforaminal area, worsening of the spondylolisthesis and a larger disc herniation to the right at L5-S1. (PX1 p.30)

The Arbitrator notes that Petitioner was not entirely forthcoming with information regarding her pre-existing back condition.

Petitioner testified that prior to her role in the Epic program:

> *I had an impingement of L5-S1 due to biking two years before and it was diagnosed by physicians at Fox Valley Orthopedic and treated with a spinal injection, well treated; and as long as I was moving and doing the normal things I did in my job prior to Epic I was just fine.* (PX.1, p.20)

Dr. Levin noted Petitioner's report of "a non-work-related issue in 2010: where she was diagnosed with L5-S1 impingement". (Id.). Petitioner reported to Dr. Levin that she was given a cortisone injection and she was "100% recovered after the injection."

While Petitioner emphasized throughout her testimony that she only suffered a L5-S1 nerve impingement in 2009 due to a biking accident, her medical records indicate a more extensive pre-existing condition. The levels at which the fusion was performed in April 2015 were the same levels noted to have been afflicted with degenerative disc disease.

The Arbitrator finds it disconcerting that Petitioner failed to provide for the Arbitrator's review medical records relating to her prior back complaints. Petitioner's medical records exhibits do not contain records prior to July 2011 and do not document Petitioner's pre-existing degenerative back condition. Respondent's Exhibits 4 and 5 do provide documentation of Petitioner's pre-existing degenerative back condition.

The Arbitrator finds Petitioner's medical history to be inconsistent with her testimony that she was "just fine" and her statement to Dr. Levin that she was "100% recovered" prior to her alleged manifestation date

The medical records demonstrate:

1. That Petitioner suffered a biking accident sometime in May of 2010;
2. On June 26, 2010, Petitioner presented to Delnor hospital with a history of left glute pain for the last month after riding her bicycle for approximately 20 miles in Wisconsin. Petitioner reported increasing pain in her buttocks over the past 2-3 days with pain so intense that she had difficulty walking;
3. On June 30, 2010, Petitioner underwent a lumbar MRI at Delnor Community Hospital. (RX 4) The MRI report noted a history of left buttock pain. The MRI findings note degenerative disk changes at L1-L2 through L5-S1, most significant at L3-L4, L4-L5 and L5-S1; a right sided L5-S1 herniated nucleus pulposus abutted and displaced the right S1 nerve root; L4-L5 bilateral facet arthritis with some foraminal stenosis bilaterally and degenerative disk changes:
4. On October 28, 2010, Petitioner presented to Dr. Cladis who noted a history of a herniated intravertebral disk. (RX5)
5. On January 20, 2011, Petitioner received an epidural steroid injection in her lumbar back.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Bonasorte,

Petitioner,

vs.

NO: 12 WC 18561

16IWCC0382

Village of Addison,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision finding that Petitioner was temporarily totally disabled from May 8, 2012 through July 22, 2012, a period of 10-6/7 weeks. The Arbitrator did not award TTD benefits as this was not disputed. However, the Arbitrator gave Respondent credit of $8,414.52 for TTD benefits paid by Respondent. There cannot be a credit against no award. The parties stipulated on the Request for Hearing form that Petitioner was temporarily totally disabled from May 8, 2012 through July 22, 2012. The Commission modifies as per the parties stipulation. The Commission affirms all else.

16IWCC0382

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.06 per week for a period of 10-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $235.00 for reasonable, necessary and related medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 64.50 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent disability of the right leg to the extent of 30%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes that Respondent paid $8,414.52 in TTD benefits and Respondent shall have credit for medical bills paid.

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

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

DATED: JUN 8 - 2016
MB/maw
o05/19/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BONASORTE, JOSEPH
Employee/Petitioner

Case# **12WC018561**

16IWCC0382

VILLAGE OF ADDISON
Employer/Respondent

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

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

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

1404 KETTER, BARRY A
111 W WASHINGTON ST
SUITE 920
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
EDWARD A JORDAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

16IWCC0382

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

JOSEPH BONASORTE
Employee/Petitioner
v.
VILLAGE OF ADDISON
Employer/Respondent

Case # **12** WC **018561**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Wheaton**, on **07/24/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **§8a medical remains open**

FINDINGS

On **02/23/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$59,934.16**; the average weekly wage was **$1,162.59**.

On the date of accident, Petitioner was **31** 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 **$8,414.52** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,414.52**.

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

ORDER

PERMANENT PARTIAL DISABILITY:
The Arbitrator finds that Petitioner sustained a permanent partial disability to the extent of **30%** loss of use of the right leg, and that Respondent shall pay Petitioner permanent partial disability benefits of **$695.78**/week for **64.5** weeks, as provided in §8(b)2, §8(e), and §8.1b(b) of the Act.

MEDICAL BENEFITS:
Respondent shall pay **$235.00** to Elmhurst Orthopedics, subject to the fee schedule, in accord with §8.2 of the Act. Further, medical benefits under § 8(a) shall be remain open and Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, provided in §8(a) and §8.2 of the Act.

CREDITS:
Respondent shall be given a credit of $8,414.52 for TTD. Respondent shall be given a credit for medical benefits that have been paid.

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

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

Signature of Arbitrator
ICArbDec p. 2

November 4, 2015
Date

NOV 5 - 2015

Joseph Bonasorte v. Village of Addison
12 WC 18561

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth on July 24, 2015. Disputed Issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

Petitioner testified at the hearing. Exhibits offered in evidence by the parties were admitted without objections.

STATEMENT OF FACTS

Petitioner testified that he was working for Respondent as an arborist on February 23, 2012. He was removing a tree with a coworker and as they were carrying a log to a wood chipper, the log fell on Petitioner's right leg. Petitioner reported the injury to his supervisor and sought medical treatment with Dr. John Nikoleit at Elmhurst Orthopedics. (PX #1 - #5)

Following the accident Petitioner first treated with Dr. Nikoleit on February 29, 2012. Petitioner reported that he injured his right knee at work. He had a prior right knee injury 10 years before with ACL reconstruction surgery. Examination found tenderness at the medial joint line, clicking sensation, pain with McMurray test, pain with valgus stressing, minimal effusion, and no ACL instability. Dr. Nikoleit diagnosed a possible torn meniscus or medial collateral ligament strain of the right knee. Petitioner was fitted with a hinged brace, placed on light duty, and sent for an MRI.

Petitioner had the MRI of his right knee on March 7, 2012. No obvious meniscal tear was noted. There was mild joint effusion and grade 2 myxoid degeneration of the lateral meniscus. On March 14 Dr. Nikoleit thought there was a questionable tear of the meniscus. He continued Petitioner on light duty. Petitioner began physical therapy for his knee. Petitioner continued to have pain and popping in his knee. On April 25, 2012 Dr. Nikoleit recommended a right knee injection and surgery.

Dr. Nikoleit performed a right knee arthroscopy on May 8, 2012, involving a partial medial meniscectomy and a trochlear chondroplasty. The post-operative diagnoses were torn medial meniscus and chondromalacia of the trochlear. Petitioner had physical therapy after surgery at Physico Sports and Rehabilitation Center through July 13, 2012, at which time Petitioner had achieved his goals. Dr. Nikoleit prescribed Synvisc injections. Petitioner followed up with Dr. Nikoleit on July 10, 2012 and reported that he was doing much better with less pain. Dr. Nikoleit recommended

Petitioner to return to full duty work. Petitioner testified that he returned to regular duty work on July 23, 2012.

Petitioner testified to continuing complaints of pain and swelling in his right knee. Although he is working full time without work restrictions he wears a brace to support his knee. His knee will lock or give out on occasion. His pain is worse when he stands for a long time. He testified that each step is painful. He still trims trees, which requires lifting and carrying tree limbs and branches. He works out of a lift bucket rather than climbs ladders.

Petitioner acknowledged that he had sustained a right ACL injury in 2002 which required surgery. He testified that he was able to work without problems up to his 2012 accident. His doctor did not tell him then that he might have ongoing problems.

Petitioner has remained under care with Dr. Nikoleit. Petitioner has a routine of treatment with injections of cortisone and Synvisc in his right knee: November 19, 2012; January 16, April 10, August 23, and December 27, 2013; February 7, March 27, May 22, November 5, and December 3, 2014; and March 11 and June 12, 2015. (PX # 2 & 5) A new MRI on March 14, 2014 showed an abnormal signal in the posterior horn and body of the medial meniscus but it was uncertain if that represented a new tear of post-operative changes. Dr. Nikoleit injects his knee twice a year, at intervals of about 6 months, with Synvisc. Dr. Nikoleit will inject cortisone periodically between the Synvisc injections. Petitioner testified that the injections give temporary but not lasting relief. Dr. Nikoleit has not modified Petitioner's work status despite the ongoing medical treatment. He has not had physical therapy since his discharge in July 2012.

Petitioner followed up with Dr. Nikoleit on March 11, 2015 with continued right knee pain. Dr. Nikoleit administered a cortisone injection and refilled Petitioner's medications. Petitioner was also seen on June 12, 2015. (PX #5) Dr. Nikoleit diagnosed right knee degenerative joint disease and gave Petitioner another Synvisc injection. Petitioner was also given a toxicology screen based upon continuing use of prescription medications.

Petitioner testified that he is still employed by Respondent as an arborist, which is the job he had at the time of the injury. He is making the same hourly pay rate as at the time of his injury. Petitioner testified that he has to lift and cut tree branches and place branches in wood chippers.

Dr. Nikoleit authored a narrative report to Petitioner's counsel dated August 13, 2014. (PX #3, #4 & #5) Dr. Nikoleit noted that he was managing Petitioner's knee complaints with conservative measures, including injections and prescriptive medication. Dr. Nikoleit opined that Petitioner's diagnosis is right knee patellofemoral degenerative joint disease and medial compartment degenerative joint disease that is related to the work injury. He also opined that Petitioner will require ongoing injections and a greater than 50% likelihood of a knee replacement.

Petitioner was examined pursuant to § 12 of the Act by Dr. Ira Kornblatt, a board certified orthopedic surgeon, on June 27, 2013 and on October 23, 2014. (RX #1 & #2)

At the first exam Dr. Kornblatt reviewed Petitioner's medical records, performed a physical examination of Petitioner's right knee, and drafted an impairment rating report. On exam Dr. Kornblatt observed Petitioner's normal gait. Petitioner was able to squat. Petitioner had reduced flexion in the knee along with crepitance. The knee was stable. Also, meniscal signs were negative. Dr. Kornblatt opined that Petitioner's injury equates to an impairment of 2% of the lower extremity. (RX #1)

Dr. Kornblatt also drafted an addendum IME and Impairment Rating Report dated October 23, 2014. (RX #2) Dr. Kornblatt took x-rays of Petitioner's right knee which he stated revealed no changes from the June 2013 x-rays and well-maintained joint spaces. Dr. Kornblatt opined that his diagnosis for Petitioner's right knee is status-post ACL reconstruction with a work related medial meniscus tear with ongoing symptomatic patellofemoral pain and medial compartment arthritis. Dr. Kornblatt also opined that Petitioner was at MMI, but would require ongoing injections and may require a total knee replacement. Dr. Kornblatt modified Petitioner's impairment rating to a class 2 modifier, but continued with his opinion that Petitioner's impairment rating is 2% of the lower extremity or 1% of the whole person.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner's current condition of ill-being regarding his right knee is causally related to his workplace accident. The Arbitrator notes that Dr. Nikoleit and Dr. Kornblatt, Respondent's IME physician, both opined that Petitioner sustained a right knee injury caused by his workplace accident on February 23, 2012 and that his current condition was causally related to the accident. Although Petitioner had a pre-existing right knee injury, there was no evidence that he was under medical care at the time of the injury or had ongoing disability or restrictions prior to the work injury.

Therefore, the Arbitrator finds that Petitioner's right knee condition is causally related to the February 23, 2012 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?

The Arbitrator finds that Respondent has not paid all appropriate charges for all reasonable and necessary medical services. Petitioner presented medical bills totaling $235.00 from Elmhurst Orthopedics and Dr. Nikoleit for an office visit and a urine toxicology screening tests. Prior to trial, Respondent's counsel stated that Respondent will agree to pay these medical bills pursuant to the fee schedule. Therefore, the Arbitrator finds Respondent liable for these medical charges, pursuant to the fee

schedule, and that said bills are to be paid directly to the medical providers per Respondent's statement at trial.

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

Petitioner's injury occurred after September 1, 2011 and therefore, permanent partial disability is determined pursuant to §8.1b of the Act. Based on the following, the Arbitrator finds that Petitioner sustained a 30% loss of use of the right leg pursuant to §8.1b(b), based on the following factors:

(i) Petitioner's impairment was evaluated twice by Respondent's retained expert, Dr. Ira Kornblatt. Dr. Kornblatt's assessments were based on his reviews of Petitioner's medical records and clinical examinations of Petitioner. In applying American Medical Association Guide to the Evaluation of Permanent Impairment, 6th Edition, Dr. Kornblatt assessed Pettioner's impairment at 2% of a leg. The Arbitrator, in noting that impairment does not equate to disability under the Act, gives this factor moderate weight.

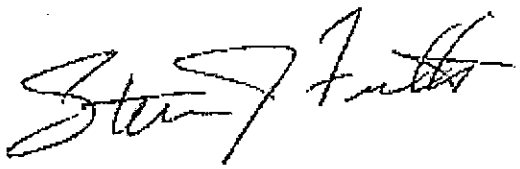
(ii) Petitioner was employed as an arborist at the time of the accident. The job activities involved lifting, bending and carrying such as cut tree branches and trunks. The Arbitrator notes that Petitioner was able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that Petitioner returned to regular duty work with no restrictions in July 2012, 2 months after his knee arthroscopy. Even though Petitioner continues to complain of right knee pain, Dr. Nikoleit has not modified Petitioner's work status. The Arbitrator therefore gives great weight to this factor.

(iii) Petitioner was 31 years old at the time of his injury. His statistical life expectancy was 47 years and his statistical worklife expectancy was 28 years. The Arbitrator gives great weight to this factor.

(iv) Petitioner returned to his prior employment following his surgery. There was no evidence that his earning capacity has been adversely affected by his injury. The Arbitrator gives no weight to this factor.

(v) Petitioner sustained an injury to his right knee which required arthroscopic repair of a torn medial meniscus and a trochlear chondroplasty. Before his surgery Petitioner went through physical therapy without significant relief. Post-operative physical therapy provided some but not total relief. Following surgery Petitioner returned to work but continued to receive periodic medical care for his continuing complaints. He has a degenerative knee joint which requires injections of cortisone and Synvisc, a synovial fluid replacement, several times a year. Petitioner's treating physician, Dr. Nikoleit, has opined that Petitioner has a greater that 50% likelihood of need a total knee replacement. Respondent's § 12 expert, Dr. Kornblatt, did not dispute Dr. Nikoleit's opinion regarding a future knee replacement or its relation to the workplace accident. The Arbitrator gives great weight to this factor.

Therefore, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 30% loss of use of Petitioner's right leg pursuant to §8(b)2 and §8.1b(b) of the Act, equaling 64.5 weeks of permanent partial disability benefits at the maximum rate of $695.78 per week.



November 4, 2015

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Field,
Petitioner,
vs.
Pinckneyville Community H S Dist 101,
Respondent,

NO: 13WC007005

16IWCC0383

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, 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 2, 2015 is hereby affirmed and adopted.

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

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

DATED: JUN 10 2016
MJB/bm
o-6/7/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FIELD, MARY
Employee/Petitioner

Case# **13WC007005**

PINCKNEYVILLE COMMUNITY H S DIST 101
Employer/Respondent

16IWCC0383

On 4/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% 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:

4377 MICHAEL MILES ATTORNEY AT LAW
PO BOX 907
CARBONDALE, IL 62903

1723 McBREARTY HART & KELLY LLC
BRIAN K McBREARTY
222 S CENTRAL AVE SUITE 200
ST LOUIS, MO 63105-3509

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

Mary Field
Employee/Petitioner

v.

Pinckneyville Community H.S. Dist. 101
Employer/Respondent

Case # **13** WC **7005**

Consolidated cases: _____

16IWCC0383

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **02/13/2015**. 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 **05/04/2012**, 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 $**42,844.88**; the average weekly wage was $**823.94**.

On the date of accident, Petitioner was **63** years of age, ***married*** with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $495/week for 70 weeks, because the injuries sustained caused the 35% loss of the left leg, as provided in Section 8(e) of the Act.

The Respondent will be responsible for the reasonable and necessary medical expenses of $80,791.88. Pursuant to a stipulation between the parties, the Respondent will pay the expenses directly to the provider and have use of the Fee Schedule or any negotiated rates. The Respondent will also receive a credit for any medical expenses paid by its group health provider pursuant to the rules and protections of section 8(j).

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

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

The Arbitrator finds the following facts:

The Petitioner testified that in the morning of May 4, 2012, she was en route to Pinckneyville Community High School, the Respondent's campus and her usual and customary place of employment. As she drove her car near the parking lot she would routinely enter, she became aware that the entrances to the lot were blocked off by vehicles as part of a "Senior Prank Day." The Petitioner also observed loud music and groups of high school students milling around in a party-like atmosphere. Due to the blockades, the Petitioner parked next the football practice field which was across a side street from the north side of the school. The Petitioner exited her vehicle and took a direct route to the school entrance. She crossed the side street and walked across a section of mowed grass that was between the sidewalk of the side street and the school parking lot. As she walked across the morning grass, she slipped, fell and suffered compound fractures to her lower left leg.

The Petitioner testified that she wasn't sure if she slipped on the wet grass or stepped in a small hole. The Petitioner further testified that the strip of grass was not flat but had a slight decline from the sidewalk to the parking lot. Photographs introduced by both parties show the section of lawn and illustrate a slight downgrade in the terrain. Although there was an entrance for motorists near the section of grass where the Petitioner fell, she testified that students' vehicles were blocking the entrance and she wanted to steer away from the students who had likely been partying for several hours. The Petitioner further testified that she would normally park in the parking space that was closest to the school doors, but this space was also in the area blocked off by the students. On the paved area of the parking lot there were no markings to guide pedestrians walking from across the street to the school. The section of grass was open from the side walk to the parking lot and there were no signs instructing pedestrians to stay off of the grass. (Petitioner's Group Exhibit 8a-c.)

The Petitioner testified that while she laying on the ground, she recalls talking with the school nurse who came to the scene, but does not remember talking with anyone else. She further testified that she was transported by ambulance to Carbondale Memorial Hospital where she was admitted onto an inpatient floor. On March 7, 2012, three days following the accident, Dr. David Wood, MD, an orthopedic surgeon, performed an open reduction internal fixation (ORIF) procedures of the Petitioner's lower left tibial pilon fracture and left distal fibula fracture. Dr. Wood's post-operative diagnoses was left tibial pilon fracture and left fibula fracture. The Petitioner testified that she went through a period of rehabilitation which included rest and physical therapy. She further testified that on November 13, 2012, Dr. Wood told her that she was as good as she was going to get and therefore she has not scheduled a follow up appointment with Dr. Wood since that date.

The Petitioner testified that her summer break consisted almost entirely of rest and rehabilitation of the left lower extremity. At the start of the Fall Semester, 2012, the Petitioner testified that she resumed her duties as a high school art teacher. She further testified that due to the residual of her injury she struggled to maintain a pace that she believed was needed in order for her to perform up to necessary standards. She testified that she could not walk around the classroom to work with art students on an individual basis, at times she had to prop her leg on a chair to reduce swelling and she always had to be careful when walking the hallways due to loss of balance. The Petitioner further testified that two years following the accident, she continues to experience pain and swelling in her lower left leg. She testified that she often wears therapeutic socks, uses a variety of pain-relieving salves, including horse liniment at night time, and takes over the counter pain medication on a frequent basis.

Superintendent Keith Hagene testified for the Respondent. He testified that he was en route to the school when he received a call on his cellphone that the Petitioner had fell and suffered injury. He testified that he was only minutes from the school at the time he received the call. He further testified that when he arrived at the scene, the ambulance was there and the Petitioner had already been packaged and placed in the ambulance. Superintendent Hagene also testified that he was able to access the parking lot where the party was taking place with his vehicle and he believed that there were better routes for the Petitioner to travel from her car to the school doors. Superintendent Hagene also testified that he believed the city owned the section of grass where the Petitioner fell but the grass is cut and maintained by the school. He described the section of grass as being similar to a "first cut" section of a golf course. He also testified that players for the school's football team would walk across the same area where the Petitioner fell but most would walk on the asphalt driveway to cross the street, not the grassy section, while going to the practice field. (See for illustration Petitioner's group exhibit 8a-c).

Former Pinckneyville Community High School student Mariah R. Scherer testified that she was a participant in the Senior Prank Day and was on the premises at the time the Petitioner fell. She testified that the Senior Prank Day was a school tradition although not a school-sponsored event. She testified that she was standing on the sidewalk that the Petitioner walked over moments before she fell. Ms. Scherer further testified that she thought there were better options for the Petitioner to travel. Ms. Scherer testified that she had previously

marked on maps and diagrams of the scene produced by the Respondent, but admitted that her circles on the drawings showing a space between the vehicles and the grass indicated a larger area than the actual space that may have been available to the Petitioner at that time. She further testified that she did not recall what kind of vehicles were blocking the entrance way or whether the vehicles were cars or pickup trucks.

The Arbitrator decides the disputed issues as follows:

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

The Arbitrator finds that the Petitioner had an accident that arose out of and in the course of her employment with the Respondent on May 4, 2012. The Arbitrator specifically finds the Petitioner to be credible. She testified that the Senior Prank Day 2012 consisted of the students' blocking the parking lot off from the teachers. Superintendent Hagene testified that the year before, the Senior Prank Day seemed to have had accelerated in aggressiveness over years past. Superintendent Hagene further testified that the administration knew that the prank was taking place before the accident occurred. The Petitioner testified that blocking teachers' parking spaces was a prank that had been performed in years past. Students were not disciplined for being involved in the prank day. The Petitioner parked in an area that provided the most direct route from her car to the school doors, although it was much farther away than her customary parking space. The school tradition of Senior Prank day while not a school-sponsored event, was implicitly approved by the school administrators and the blocking the teachers from parking in their customary parking spaces was a known activity. Accordingly, the Petitioner was within the scope of her employment when she was directed to park across the street from the school.

After she parked, the Petitioner took the most direct route from her car to the school doors, while maintaining a distance from the students, their music and their vehicles. The Petitioner testified that although she was not scared of the students, she was focused on their activities and desired to avoid close contact. Although the Petitioner was not exactly sure whether she slipped on the morning grass, or tripped in an unseen hole, the pictures of the scene indicate that the strip of lawn dips slightly. Under the circumstances, the Petitioner, as a teacher and therefore an intended target of the prank, experienced an increased risk of harm than that of the general public. Furthermore, her choice of route across the mowed grass and away from the students, the vehicles, and the party was reasonable. *Cf. Anderson v. Oakton Community College,* 13 IWCC 0520.

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

The Arbitrator finds that the Petitioner's current condition of ill-being as it relates to the left tibial pilon fracture and left distal fibula fracture is related to the work accident. The evidence supports that the Petitioner slipped, fell, and broke her leg. The treatment records reflect emergent treatment for compound displaced fractures of the tibia and fibula, hospital admittance, surgery, therapy, and post-surgery follow up care. In April 2014, the Petitioner sought a follow up visit with Dr. Craig Furry, her primary physician for concerns with the left leg following a minor incident involving her grandson—this visit is also related to the work accident.

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

The Arbitrator finds that the following bills are reasonable and necessary:

Pinckneyville Ambulance Service	$971
Orthopedic Institute of Southern Illinois	$7297
Memorial Hospital of Carbondale	$60,631.78
Cape Radiology Group	$237.00
Brigham Anesthesia	$1653.00

Southern Illinois Medical Services	$3291.00
Perry County Health Department	$3291.00
Dr. Craig Furry	$81.00
Marshall Browning Hospital	$6630.00
Total	**$80,791.78**

Pursuant to a stipulation between the parties the Respondent will pay the bills directly to the providers, have use of the Fee Schedule or any negotiated rate, and receive a credit for any bills paid by its group health provider pursuant to Section 8(j).

L. What is the Nature and Extent of the Injury?

Pursuant to Section 8.1b of the Act, several factors are to be considered in determining permanent partial disability ("PPD").

With regard to the initial factor, enumerated in Section 8.1.b(a), no AMA impairment rating was submitted into evidence. As such, this factor will not be part of the PPD determination. *Caruso v. Costco* 14 IWCC 0484 (2014)

With regard to factors two (occupation), three (age), and four (future earning capacity), the Petitioner testified that she returned to her job as a high school art teacher at the start of the following school year. She further testified that she struggled the entire year with performing her duties. At the end of the 2012-2013 school year, she testified that she was eligible for retirement benefits and therefore retired. She testified that she loved teaching and her ongoing problems with her left leg were significant factors in her decision. At the time of the injury she was 63-years old.

The final factor involves evidence of disability corroborated by the treating medical records. The Petitioner testified that two years following the accident, she continues to experience pain and swelling in her lower left leg. She testified that she often wears therapeutic socks, uses a variety of pain-relieving salves, including horse liniment at night time, and takes over the counter pain medication on a frequent basis. The Petitioner's testimony is corroborated by the medical evidence. A photograph of an X-Ray taken of the left lower leg and foot show significant hardware installed in the Petitioner's lower extremity. (Petitioner's Exhibit O). Dr. Wood stated in his medical report dated August 28, 2012, that he did not recommend elective removal of the hardware. (Petitioner's Exhibit 3) In his November 13, 2012, note, Dr. Wood encouraged the Petitioner to increase her activities as much as possible and to "get the most out of it." He also warned about eventual arthritis of the left ankle. (Id.)

Based on the above factors, the Arbitrator finds support in his finding that the Petitioner sustained the permanent loss of 35% of the left leg pursuant to Section 8(e)12 of the Act.

Signature of Arbitrator

3/27/15
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

Cathy Purcell,

Petitioner,

vs. NO: 14WC018228

Rome School,

Respondent,

16IWCC0384

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent, herein and notice given to all parties, the Commission, after considering the issues of medical expenses, 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 20, 2015, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 10 2016
MJB/bm
o-6/7/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

PURCELL, CATHY
Employee/Petitioner

Case# **14WC018228**

ROME SCHOOL
Employer/Respondent

16IWCC0384

On 8/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1239 KOLKER LAW OFFICES PC
JASON R CARAWAY
9423 W MAIN ST
BELLEVILLE, IL 62223

0560 WIEDNER & McAULIFFE LTD
KRISTOPHER DUNARD
1 N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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)

Cathy Purcell
Employee/Petitioner

v.

Rome School
Employer/Respondent

Case # **14** WC **18228**

Consolidated cases: **N/A**

16IWCC0384

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **3/6/15**. 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. ☒ 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 _____

16IWCC0384

FINDINGS

On the date of accident, **2/26/13**, 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 $**15,131.35**; the average weekly wage was $**290.98**.

On the date of accident, Petitioner was **55** 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

Respondent shall pay outstanding reasonable and necessary medical services of $4,528.10, as set forth in Petitioners' Exhibit 12, pursuant to the fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize and pay for the pending surgery purposed by Dr. Matthew Gornet.

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

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

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

Signature of Arbitrator

8/20/15
Date

AUG 20 2015

ICArbDec19(b)

FINDINGS OF FACT

At the time of her accident Petitioner was a teacher's aide and bus monitor for Respondent. On February 26, 2013 the bus she was working on was rear ended by a car. (Tr. 12) At the time of impact Petitioner was moving towards the seat in front of her. She was violently thrown back in her seat. The vehicle which struck the bus caught fire and became entangled with the bus after the collision. (Tr. 13) Petitioner immediately began to care for the children on the bus, and during this time did not notice any kind of pain. (Tr. 14) Petitioner testified she did start to experience pain in her neck and back later in the evening on the day of the accident. By the evening she had restricted range of motion in her neck. (Id.)

Petitioner testified she had no prior neck pain complaints like she began to experience after the accident. She saw her primary care provider the next morning. (PX. 1) She presented with headaches and neck pain at 10/10 on the pain scale. She was taken off work for 3 days. Other than these three days, Petitioner has continued to work. (Tr. 19) Petitioner initially attended two months of physical therapy. (PX. 2) During this time an MRI was taken at Salem Hospital which revealed disc herniations at C4-5 and C6-7, as well as a disc bulge at C5-6. (PX. 4)

Petitioner was then referred for orthopedic evaluation and treatment at the Orthopedic Center of Southern Illinois (OCSI) (PX. 5) She first saw Dr. Steinke. He causally connected her headaches and neck pain to the bus accident and ordered an additional month of physical therapy. Petitioner next underwent three injections at the hand of Dr. Smith at OCSI. (Id.) In June 2013, Dr. Steinke indicated that if her symptoms did not improve, she would possibly be a candidate for a cervical fusion at C5-6. Petitioner received no lasting relief from the injections. (PX. 5 & Tr. 17)

Dr. Steinke then left OCSI and Petitioner's care was transferred to Dr. Donald Kovalsky. (PX. 5) Dr. Kovalsky only saw Petitioner once and opined he disagreed with his former colleague Dr. Steinke's recommendation for a disc replacement. Instead, Dr. Kovalsky believed that if her neck symptoms did not improve, the surgical procedure would consist of a diskectomy and fusion at C5-6. (Id.) Petitioner testified she was dissatisfied with Dr. Kovalsky and the way he treated her and that she had to wait for six hours to see him. (Tr. 19) Petitioner then asked her primary care provider for a referral to Dr. Matthew Gornet.

Dr. Gornet ordered an MRI which revealed a disc herniation at C5-6 with a fragment of disc encroaching on her right foramen. Dr. Gornet causally connected her symptoms and diagnosis' to the bus accident. After another failed injection at the hands of Dr. Boutwell, Dr. Gornet recommended a single level disc replacement at C5-6. (PX. 6)

Petitioner testified she wishes to have the surgery proposed by Dr. Gornet. She credibly testified that she continues to have major headaches that feel like someone is hitting her in the head. (Tr. 20) She also credibly testified that she has a reduced and painful range of motion in her cervical spine. (Id.) Petitioner continues to try to manage these symptoms with Flexeril, Ibuprofen and Aleve so that she can work. (Tr. 21)

On May 1, 2014, Petitioner was examined by Dr. Lange at the request of the Respondent. (PX. 11) Dr. Lange was then deposed. On direct examination Dr. Lange opined one of the reasons he disagreed with Dr. Gornet's proposed surgery was that Petitioner never presented with classical radicular symptoms. (PX. 11, 220)

On cross examination however, Dr. Lange admitted the Petitioner, did in fact present with right shoulder pain when she saw Dr. Gornet on June 28, 2014. (PX. 11, 236) Dr. Lange further admitted she also presented with trapezius pain upon her first visit with Dr. Gornet. (PX. 11, 237)

Dr. Lange causally connected Petitioner's current neck pain to the bus accident. He opined she aggravated her pre-existing degenerative disease process in her cervical spine. (PX. 11, 221) He also testified the treatment she had received prior to his examination was reasonable and necessary. (PX. 11, 221). Dr. Lange also opined Petitioner was not at MMI, recommending a cervical facet injection. (PX. 11, 223) However, Dr. Lange opined the surgery proposed by Dr. Gornet was not causally connected to the accident, and that it had no chance of helping the Petitioner. (PX. 11, 245) Dr. Lange concluded his opinions by indicating the Petitioner would have causally connected neck pain into the future and that she should avoid continuous or repetitive overhead work as a result of the bus accident. (PX. 11, 247)

CONCLUSIONS OF LAW

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

The medical records and opinions contained therein, in conjunction with Petitioner's credible testimony, indicate there is a causal connection between Petitioner's bus accident of February 26, 2013 and her current state of ill-being. Further, both Petitioner's treating physicians and Respondent's §12 examiner, agree that Petitioner's ongoing symptoms are causally related to the motor vehicle accident.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner's current condition of ill being is related to the accident.

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

Issue (K): Is Petitioner entitled to any prospective medical care?

Again, Petitioner's treating physicians and Dr. Lange are in agreement that all of the treatment which Petitioner received up to the point of Dr. Lange's §12 exam on 5/1/14 was both reasonable and necessary. Respondent does not dispute these charges. Rather the dispute involves Respondent's liability for the charges related to an epidural steroid injection performed on 5/19/14 and prospective treatment recommended by Dr. Gornet.

Dr. Lange does not feel Petitioner is a surgical candidate. Dr. Steinke, Dr. Kovalsky, and Dr. Gornet all agree Petitioner is a surgical candidate although they recommend distinct procedures. Dr. Steinke and Dr. Gornet believe C5-6 disc replacement surgery is the favored procedure while Dr. Kovalsky favors a discectomy and fusion at C5-6.

While he disagreed with Dr. Gornet's surgical recommendation, Dr. Lange himself causally connected her ongoing cervical pain to the accident and recommended further care. In addition he opined Petitioner's cervical pain would continue into the future. Petitioner has undergone significant conservative care involving months of physical therapy and four injections which did not provide significant lasting relief. Petitioner's

testimony regarding these conservative measures and their lack of effectiveness was credible and supported by the medical records submitted at arbitration.

The Arbitrator further finds the opinions of Dr. Gornet, Dr. Kovalsky, and Dr. Steinke with regard to the need for surgical intervention more persuasive than that of Dr. Lange. With regard to which surgical procedure to perform the Arbitrator finds the procedure recommended by Dr. Gornet to be reasonable.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the medical treatment rendered to Petitioner up to the date of hearing, including the injection performed on 5/19/14, has been both reasonable and necessary. Further the Arbitrator finds the surgery recommended by Dr. Gornet is both reasonable and necessary. Respondent shall pay medical expenses of $4,528.10 as set forth in PX12 pursuant to the fee schedule and shall authorize and pay for the surgical procedure recommended by Dr. Gornet and any other treatment associated there with.

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.

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

Nancy Carlson,
Petitioner,
vs.

NO: 12WC028830

State of Illinois,
Respondent,

16IWCC0385

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 & 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 14, 2015, is hereby affirmed and adopted.

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

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

DATED: JUN 10 2016
MJB/bm
o-6/7/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARLSON, NANCY
Employee/Petitioner

Case# **12WC028830**

STATE OF ILLINOIS
Employer/Respondent

16IWCC0385

On 12/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0146 CRONIN PETERS & COOK
KENNETH D PETERS
221 N LASALLE ST SUITE 1454
CHICAGO, IL 60601

5782 ASSISTANT ATTORNEY GENERAL
KELLY KAMSTRA
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

DEC 4 = 2015

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

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

NANCY CARLSON
Employee/Petitioner

Case #12 WC 28830

v.

16IWCC0385

STATE OF ILLINOIS
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on November 16, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On April 12, 2012, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $83,573.00; the average weekly wage was $1,607.17.
- At the time of injury, the petitioner was 59 years of age, single with no children under 18.
- The parties agreed that the respondent paid $1,051.19 in medical benefits and is entitled to a Section 8(j) credit for the amount.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $1,071.45/week for 7-2/7 weeks, from May 24, 2012, through July 13, 2012, which is the period of temporary total disability for which compensation is payable.
- The petitioner's request for permanent partial disability benefits is denied.
- The respondent shall pay the petitioner compensation that has accrued from April 12, 2012, through November 16, 2015, and shall pay the remainder of the award, if any, in weekly payments.
- The petitioner is awarded her out-of-pocket costs of $579.44.

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

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

Robert E. Williams

2015December 2, 2015
Signature of Arbitrator

December 2,

Date

DEC 4 - 2015

FINDINGS OF FACTS:

16IWCC0385

The petitioner, a data analyst with duties requiring computer keyboarding and processing, saw Dr. Weidrich on April 12, 2012, and reported pain and numbness in her hands and right elbow. She felt that her hands were like before her two prior right and left carpal tunnel releases. She complained that her hands were getting worse and that she only uses her hands to type continuously. She reported a diagnosis of Dupuytren's disease in her left hand and a prior right lateral epicondylitis. His diagnosis was bilateral carpal tunnel syndrome, epicondylitis lateral elbow and Dupuytren's disease. An EMG on April 16th revealed bilateral median neuropathies at her wrists. The doctor limited the petitioner's use of her hands on April 19th. The petitioner took sick leave for five days from April 19th through the 23rd, and then returned to work.

On May 23rd, the petitioner reported no relief of her right elbow symptoms with physical therapy and a painful right carpal tunnel that wakes her up. Dr. Wiedrich opined that the EMG test showed that carpal tunnel syndrome was worse than before her prior surgeries. The petitioner was advised to stop working. The petitioner reported falling onto her left hand and thumb on June 20th but felt that her left carpal tunnel was improving. The petitioner reported improved but continuing hand and right elbow symptoms on July 12th. She was released to work activities with limited use of her hands. On August 1st, the petitioner reported some increased but tolerable symptoms with four-hour workdays. She reported increased symptoms with work and gradual improvement while resting at a follow-up on December 21st and waxing and waning but better symptoms on March 22 and July 24, 2013. Dr. Wiedrich noted no change in the petitioner's symptoms on November 14, 2013, and opined that her symptoms were stable. At follow-ups on May 5

and November 3, 2014, Dr. Wiedrich noted waxing and waning symptoms aggravated by work and relieved with rest.

The petitioner has a history of bilateral carpal tunnel syndrome, and arm and wrist pain. She had a right carpal tunnel release on April 27, 1998, and another right decompression on October 19, 2004. On April 7, 2005, the petitioner had a left carpal tunnel release. On December 14, 2010, she had surgery for release of her left index, long and ring trigger fingers. She was also diagnosed with Dupuytren's Disease. The petitioner was diagnosed with left lateral epicondylitis in May 2009.

FINDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF THE EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner proved by a preponderance of the evidence that she sustained repetitive traumas to her wrists on April 12, 2012, arising out of and in the course of her employment with the respondent. Although the petitioner had pre-existing carpal tunnel syndromes with her hands, when she sought medical care for her hands on April 12, 2012, she felt that her hand symptoms were the same as they were before her carpal tunnel releases. Also the petitioner's work duties required mostly continuous computer keyboarding, which she felt increased her hand symptoms.

The petitioner failed to prove by a preponderance of the evidence that she sustained a repetitive trauma to her right elbow on April 12, 2012, that arose out of and in the course of her employment with the respondent.

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

The medical care rendered the petitioner for her bilateral carpal tunnel syndrome was reasonable and necessary. The petitioner is awarded her out-of-pocket costs of $579.44. The balance of her medical costs was paid by her group health insurance. The medical care rendered the petitioner for her right elbow was not reasonable or necessary and is denied.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that the current condition of ill-being with her bilateral carpal tunnel syndrome is causally related to the work injury. The petitioner failed to prove that her current condition of ill-being with her right elbow is causally related to a work injury.

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

The petitioner was off of work and entitled to temporary total disability benefits from May 24, 2012, through July 13, 2012. The respondent shall pay the petitioner temporary total disability benefits of $1,071.45/week for 7-2/7 weeks, from May 24, 2012, through July 13, 2012, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner's claim #99 WC 67443 for bilateral carpal tunnel syndrome was settled for 26% loss of use of the right hand and 15% loss of use of the left hand on July 17, 2006.

There is no AMA impairment rating or evidence concerning the impact of the petitioner's injury in regard to her occupation, age or future earning capacity, as delineated in Section 8.1(b)(i) through (iv) of the Act, nor can any effect be reasonably inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner complains of tingling fingertips and problems with keyboarding. She has flare-ups and her right hand is worse than her left hand. The petitioner is permanently limited to four hours of keyboarding per day with 5-minute breaks after 20 minutes of typing and a lifting restriction of less than ten pounds.

The petitioner failed to prove that she is entitled to permanent partial disability benefits for her bilateral carpal tunnel syndromes. The evidence is insufficient to establish that the petitioner has a disability greater than 26% for her right hand or 15% for her left hand. In addition, the petitioner failed to prove by clear and convincing evidence that her typing duties were the cause of her recurrent carpal tunnel syndrome. It is only probable that her typing duties played a part in the worsening of her bilateral hand symptoms. In addition, Dr. Vender opined that the petitioner had a systemic predisposition for developing musculoskeletal and neurologic abnormalities and his physical examination disclosed only limited findings. The petitioner's request for permanent partial disability benefits 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 COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael W. Staine,

Petitioner,

vs. NO: 13WC 19605

Brius Telecom Solutions, LLC.,

Respondent,

16IWCC0386

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 9, 2015, is hereby affirmed and adopted.

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

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

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

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

DATED: JUN 10 2016
o041416
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

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

STAINE, MICHAEL W
Employee/Petitioner

Case# **13WC019605**

BRIUS TELECOM SOLUTIONS LLC
Employer/Respondent

16IWCC0386

On 11/9/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0222 GOLDBERG WEISMAN & CAIRO LTD
DAVID L CAPLAN
1 E WACKER DR 38TH FL
CHICAGO, IL 60601

2837 LAW OFFICES JOSEPH MARCINIAK
JAMES MIRRO
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michael W. Staine
Employee/Petitioner

v.

Brius Telecom Solutions, LLC
Employer/Respondent

16IWCC0386

Case # 13 WC 19605

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago** on **August 25, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0386

FINDINGS

On the date of accident May 29, 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 regarding the left shoulder is causally related to the accident, Petitioner current condition of ill-being regarding his alleged right shoulder and cervical injury ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $ 88,200.00; the average weekly wage was $ 2,940.00.

On the date of accident, Petitioner was 41 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 $ 107,676.73 for TTD, $ 0.00 for TPD, $ 0.00 for maintenance, and $ 0.00 for other benefits, for a total credit of $ 107,676.73.

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

ORDER

Petitioner's current condition of ill-being regarding the left shoulder is causally related to the accident. Petitioner current condition of ill-being regarding his alleged right shoulder and cervical injury is not causally related to the accident.

Petitioner has not proven, by a preponderance of the evidence that he is entitled to prospective medical treatment therefore, none is awarded.

Respondent shall be given a credit of $**107,676.73** for TTD, $**3,567.75** for TPD, and $**0.00** for maintenance benefits, for a total credit of $**107,676.73**.

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.

Finding of Facts

The disputed issues in this matter are: 1) accident; causal connection; 3) medical bills; 4) temporary total disability; 5) temporary partial disability; and prospective medical treatment. *See,* AX1.

Mr. Michael W. Staine ("Petitioner") alleges injuries to his left shoulder, right shoulder and cervical spine incurring on May 29, 2013. He testified that he was working for Brius Telecom Solutions, LLC ("Respondent") at a cell site when he tripped on conduit and fell into a cabinet, trying to catch himself with his left arm. Petitioner went to Winfield Moody Health Center on May 31, 2013, for a follow up visit for muscle spasms and twitching all over the body. The history noted pain in the back of the left shoulder for two to three (2-3) days. He next went to Dr. Silver on June 6, 2013, where history was noted as working on May 29, 2013, when he tripped on a conduit and tried to stop his fall by grabbing a pole with his left arm and wrenching his shoulder. Diagnosis was left shoulder rotator cuff impingement and he was given a cortisone injection and referred for physical therapy. He returned to Dr. Silver on July 30, 2013, where continued pain in the left shoulder was noted. Petitioner saw Dr. Dasgupta on August 27, 2013, presenting with right upper extremity pain and it was noted he had been treated previously for low back pain. Tr. pp. 33-34; PX2-4, 5.

An MRI of the left shoulder, performed on September 23, 2014, showed a suspected small focal tear involving the mild insertional fibers of the distal supraspinatus tendon; at least partial-thickness and involving the bursal surface. An MRI of the right shoulder, performed the same date, showed mild tendinosis and/or strains of the distal supraspinatus and infraspinatus tendons with suspected shallow fraying along the bursal surface of the distal supraspinatus tendon. Petitioner returned to Dr. Silver on October 1, 2013; and arthroscopic surgery for the left shoulder was recommended.

Petitioner subsequently changed his mind about surgery and wanted to try additional conservative care first, including injections. His condition did not improve, and surgery was again scheduled for December 13, 2013. The surgery was then rescheduled to the end of January 2014, but petitioner had not received cardiac clearance. Petitioner again saw Dr. Silver on March 7 2014, where it was noted he was to do a stress test over the next three days and will proceed with surgery, if he got clearance. Petitioner finally underwent left shoulder arthroscopy by Dr. Silver on May 20, 2014. PX2.

Petitioner started physical therapy, and then returned to Dr. Silver on July 18, 2014 wherein the doctor noted right shoulder pain and claimed that Petitioner injured it at the time of the original injury. Petitioner underwent examination of the cervical spine by Dr. Patel, on September 15, 2014, and a October 22, 2014 MRI of the cervical spine showed degenerative cervical spondylosis with broad-based disc bulges. On October 29, 2014 Dr. Silver recommended a right shoulder arthroscopy. PX4.

Petitioner subsequently underwent an independent medical examination ("IME") by Dr. Forsythe on December 29, 2014. He provided an accident history of tripping on a conduit when he lunged with his left upper extremity to hold onto something and felt pain, and that his right shoulder subsequently struck a bank of cabinets. Dr. Forsythe found that the petitioner likely sustained a contusion of the right shoulder which has since resolved; and a left shoulder rotator cuff strain, which was

subsequently treated with arthroscopy. The doctor opined that he would consider both conditions causally related if, in fact, the petitioner's stated history to him was accurate. He found Petitioner manifested mild symptom magnification with inconsistent effort and non-physiological responses, and that the left and right shoulder examinations were essentially normal with subjective complaints not supported by objective findings. As such, he recommended the Petitioner return to full duty work, and that no further treatment was indicated. RX1.

A repeat cervical MRI performed on February 23, 2015, was read to show a disc bulge at C6-7. Petitioner saw Dr. Mehta on May 12, 2015 and an EMG was recommended, following review of the cervical MRI and another injection. He returned to Dr. Mehta on June 9 2015, and it was noted that the neck pain was much better. The petitioner returned periodically for follow-up visits with Dr. Silver, who continued to recommend right shoulder arthroscopy, as of July 30, 2015. PXs 2-4.

Deposition of Dr. Ronald Silver, dated June 29, 2015

In his evidence deposition, the doctor stated that Petitioner fell to the ground on his right shoulder. Later in the deposition he testified that the initial note referred to Petitioner falling on the left shoulder. He then proceeds to claim that petitioner fell on both shoulders; hitting the ground on one shoulder and then rolling over on his other shoulder. Not only does that mechanism of injury seem highly unlikely, it is also unsupported by the petitioner's testimony at hearing. Dr. Silver agreed that there is no mention of any injury or pain complaints to the right shoulder or cervical spine in his records for three (3) months following the date of accident. He also testified that it is his practice to take accurate notes. However, he then goes on to claim that he had a "personal recollection" that the petitioner initially told him about the right shoulder. The Arbitrator notes that this doctor's testimony regarding the petitioner mechanism of accident is confusion and contradictory. PX1.

Deposition of Dr. Amit Mehta, dated June 11, 2015

On direct examination, this doctor testified that the petitioner's condition of ill-being regarding his neck and right should were causally related to the accident of May 29, 2013; after cross-examination, after confirming that the medical records hold no reference to any injury to these body parts for at least three (3) after the accident; the doctor admitted that it was possible that Petitioner's complaints regarding those regions were not related to this accident. PX3.

Conclusions of Law

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id.

The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a Petitioner testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).
It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).
The Illinois Supreme Court has held that a Petitioner's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a Petitioner's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill. App. 3d 665, 674 (2009).

The parties agree that Petitioner sustained an accidental injury to his left shoulder. However, there is a dispute as to whether the petitioner injured his right shoulder and cervical spine during the accident that occurred on May 29, 2013. The accident histories, as documented by various medical providers over approximately three (3) months following the accident date, only mention an injury to the left shoulder. Petitioner first went to Winfield Moody Health Center on May 31, 2013, where a history is given of pain in the back of the left shoulder for two to three (2-3) days. There is no mention of injury or pain complaint for the right shoulder or cervical spine. Petitioner first saw Dr. Silver on June 6, 2013 and reported that he tripped on a conduit and "tried to stop his fall by grabbing a pole with his left arm and wrenched the left shoulder feeling his left shoulder pop and then fell to the ground on the shoulder". Again, there is no mention of any injury or pain complaint involving the right shoulder or cervical spine. Petitioner continued to follow-up with Dr. Silver; and the July 30, 2013 note again does not mention any injury to the right shoulder or cervical spine.

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

In order for an injury to be deemed compensable, Petitioner must establish it arose out of and in the course of the employment. "An injury 'arises out of' employment when it originates from some risk related to the employment, thereby establishing a causal connection between the injury and the occupation." *Wise v Industrial Commission,* 54 Ill.2d 138, 142 (1973); *Material Service Corp. v. Industrial Commission,* 53 Ill.2d 429, 292 N.E.2d 367; *Thurber v. Industrial Commission,* 49 Ill.2d 561, 276 N.E2d 316. "A compensable injury occurs 'in the course of' employment when it is sustained while Petitioner is at work or while he performs reasonable activities in conjunction with his employment." *Wise v Industrial Commission,* 54 Ill.2d 138, 142 (1973); *Hydro-Line Manufacturing Co. v. Industrial Commission,* 15 Ill.2d 156, 154 N.E.2d 234; *Associated Vendors, Inc. v. Industrial Commission,* 45 Ill.2d 203, 258 N.E.2d 354.

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n.,* 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A Petitioner must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *Caterpillar Tractor Co. v. Industrial Comm'n.,* 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Comm'n,* 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *Darling v. Industrial Comm'n,* 176 Ill.App.3d 186, 193 (1986).

The petitioner's initial visit to AthletiCo for physical therapy was on August 6 2013; and pain complaints were only noted for the left shoulder. It was not until his August 20, 2013 follow-up at AthletiCo, that there was any mention of a right shoulder issue. The first mention of right shoulder pain in Dr. Silver's records, is on August 29, 2013, wherein he states that the right shoulder is also troubling Petitioner, due to the overuse he has placed over the past few months. The doctor adds a postscript to that note stating that the petitioner fell on his right shoulder, so the symptoms are a combination of the original injury and overuse as well. The Arbitrator notes that that contention is contradicted by the testimonies of Dr. Silver and the petitioner.

The petitioner testified at hearing that he crashed into a cabinet, holding a laptop in his right hand; stating that he tried to catch himself and had pain in his left shoulder. Not only was there no report of right shoulder pain for three (3) months after the accident, but the histories given in the medical records state various mechanisms of injury. Dr. Silver's testimony as to accident history is also contradictory. In his evidence deposition, he stated that Petitioner fell to the ground on his right shoulder. Later in the deposition he testified that the initial note refers to falling on the left shoulder. He then proceeds to claim that the petitioner fell on both shoulders, hitting the ground on one shoulder and then rolling over on his other shoulder. Not only does that mechanism of injury seem

highly unlikely, it is also wholly unsupported by petitioner's testimony at hearing. Dr. Silver agreed that there is no mention of any injury or pain complaints to the right shoulder or cervical spine in his records for three (3) months following the date of accident. He also testified that it is his practice to take accurate notes. However, he then goes on to claim that he had a "personal recollection" that the petitioner had initially told him about the right shoulder. The Arbitrator does not find the testimony of Dr. Silver to be persuasive, regarding the mechanism of Petitioner's injury.

Dr. Forsythe provided an IME opinion that he would consider both alleged shoulder injuries to be causally related to the alleged work accident, "if in fact that patient's stated history is accurate". As has been pointed out, the accident histories are inconsistent and contradictory. Furthermore, the doctor opined that the petitioner sustained a contusion to the right shoulder which has since resolved. This is consistent with the objective testing; while the left shoulder MRI showed a partial thickness tear of the rotator cuff, the right shoulder MRI does not. He found both left and right shoulder examinations to be essentially normal, with Petitioner's subjective complaints not supported by objective findings. The Arbitrator also notes that the petitioner has returned to work as of April 8, 2015, despite his treating physicians stating that he could not work. This further supports the IME doctor's note of symptom magnification, inconsistent effort on strength testing; and non-physiological responses to provocative maneuvers. The Arbitrator finds the opinion of Dr. Forsythe to be more persuasive than that of Dr. Silver. Based on the inconsistent mechanisms of injury, gaps in treatment and reporting of right shoulder complaints, lack of objective findings; and Petitioner's ability to return to work, the Arbitrator does not find the right shoulder injury to be causally related to the work accident.

With respect to the alleged cervical injury, the records show there were no cervical complaints for over a year after the work accident. Petitioner saw Dr. Dasgupta at Elmwood Park Same Day Surgery Center on August 27, 2013 and noted an injury to the left shoulder on May 29, 2013. He notes he was improving with physical therapy for the left shoulder, but now has right-sided shoulder and arm pain.

In the October 28, 2013 follow-up visit, complaints are only noted in the shoulders. Indeed, the first injection done on November 12, 2013, is to the right shoulder. The Petitioner did not return to Elmwood Park until September 15, 2014, which is the first note of neck complaints. The cervical MRI on October 22, 2014 was limited and showed only disc bulging. On May 12, 2015, the petitioner noted that his neck pain is much improved, and an EMG was recommended. Dr. Mehta testified in his evidence deposition, that petitioner injured his left shoulder on the date of accident, and that he didn't fall or strike the right shoulder or neck. He further stated that there was no report of a cervical injury or pain complaints after the work accident. Dr. Mehta testified that the cervical complaints may not be related to the work accident, that the cervical MRI results may or may not correlate to the accident; and that he has not taken the petitioner off work, due to these alleged maladies. Due to the lack of cervical complaints for over a year after the accident, the lengthy gap in treatment and Dr. Mehta's equivocation as to causal connection, the Arbitrator finds that the cervical spine complaints are not causally connected to the work 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 expenses?

The Arbitrator finds that medical services provided to the petitioner for the left shoulder incurred through the December 29, 2014 IME date were reasonable and necessary. The Arbitrator further finds that the respondent has paid all charges incurred through December 29, 2014, the date to the IME. Because Petitioner has not proven, by a preponderance of the evidence, that his condition of ill-being with respect to the right shoulder and cervical spine are causally related to the work accident, the charges for those medical services subsequent to the December 29, 2014 are not awarded. Because the Arbitrator finds Dr. Forsythe's opinion persuasive with respect that no further treatment is required for the left shoulder; charges for medical services for the left shoulder, subsequent to the December 29, 2014, are also denied.

K. Is Petitioner entitled to any prospective medical care?

The petitioner has not proven, by a preponderance of the evidence, that he is entitled to prospective medical care, therefore it is not awarded.

L. What temporary benefits are in dispute?

The parties are in agreement that temporary partial disability ("TPD") is owed from June 8, 2013 through June 28, 2013. Temporary total disability benefits ("TTD") were properly paid from July 1, 2013 through January 21, 2015. The Arbitrator finds the opinion of Dr. Forsythe to be persuasive, with regards to Petitioner's ability to return to work after January 21, 2015. In addition, the Arbitrator concludes that Petitioner's condition of ill-being with respect to the right shoulder and cervical spine are not causally related to the work accident. As such, additional TPD and TTD benefits are denied.

16IWCC0386

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC19605
SIGNATURE PAGE

Signature of Arbitrator

November 9, 2015
Date of Decision

NOV - 9 2015

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patricia A. Walker,

Petitioner,

vs. NO: 11 WC 8621

Illinois Dept. of Human Services,

Respondent,

16IWCC0387

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, notice, medical bills and permanent disability and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and finds that the Petitioner failed to prove that her current condition of ill-being was causally connected to the alleged accident on September 20, 2010.

The Petitioner testified that the last day she actually worked for the Respondent was on June 16, 2010. She retired from Respondent for reasons unrelated to this alleged claim in November of 2012. At Arbitration she testified that she worked for Respondent since 1996 and her job title was data entry/office work. She then worked at Tazewell around 2002 or 2003. She testified that over 50% of her job was data entry. Her wrists would rest on the desk while she was keyboarding and that her hands were bent upwards. (Transcript Pgs.11-18)

She claimed that the chair she used in Tazewell was defective and wouldn't work. It was dropped down below the average comfortable position to do her work. It created numbness in her arms and hands which went clear up to her elbows. She would have problems at night. She

wanted a new chair because the one that she had was unfit for her to do her job. She testified that she took a doctor's note to Tazewell asking for a new chair. She did not have the note available at the Arbitration hearing. (Transcript Pgs. 18-23)

Petitioner further testified that she wore splints on both wrists. She wore them at home, at work and to bed. She got them from a doctor but she could not remember which doctor she had seen. She eventually saw Dr. Garst on September 20, 2010 and told him about her hand numbness. She saw him again in December and was referred to Dr. Mitzelfelt in January 2011. Mitzelfelt ordered an EMG and then did carpal tunnel surgery on her left on March 31, 2011 and then on her right on May 15, 2012. (Transcript Pgs. 24-27)

Petitioner claimed that she filled out the Workers' Compensation notice of injury report on October 26, 2010 and gave it to Respondent on that date. Sue Beeney was the representative of the Respondent that she gave the notice to. She further alleges that she got a lawyer on March 2, 2011 because she was not getting any response back from Springfield. She was assigned a caseworker although she further testified that she doesn't have that information with her at the Arbitration hearing. (Transcript Pgs. 37-38)

The Commission takes note of Respondent Exhibit 2 which is the employee's first notice of accident. It is dated October 26, 2010 but stamped received by Department of Human Services on June 16, 2011.

Dr. Mitzlfelt, who originally treated Petitioner for an unrelated knee replacement, saw the Petitioner on February 17, 2011. On that date he received a history of the Petitioner complaining of bilateral hand numbness and tingling that has been getting progressively worse. He noted that this occurs especially when she works. (Petitioner Exhibit 2) Mitzlfelt testified at his deposition that based on a reasonable degree of medical certainty her job was definitely an aggravating factor. When he had seen her the first time she had mentioned that the numbness and tingling had been getting worse especially in respect to her work. He testified that it was getting harder for her to do it. (Petitioner Exhibit 3 Pgs. 7-9) Petitioner last worked for Respondent 10 months prior to that date.

The Commission finds the testimony of Dr. Williams more persuasive than that of Dr. Mitzlfelt. Dr. Williams testified that he felt that her carpal tunnel syndrome was neither aggravated nor caused by her work. The typing she described was intermittent and Petitioner did other tasks like answering the phone, pushing buttons, doing the mail, stapling and collating papers. It is also significant that Petitioner was not working at the time she presented to Dr. Garst of her carpal tunnel symptoms. If a person hasn't worked since 2010 and her symptoms were no better months later, it would lead one to believe that something besides her work was contributing to her symptoms. One would expect that when one takes away the thing that is allegedly bothering you, your symptoms would actually improve and not stay the same or continue to worsen. (Respondent Exhibit 1 Pgs. 10-11)

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner failed to prove that her bilateral carpal tunnel syndrome was causally connected to the job duties she

16IWCC0387

performed until June 16, 2010.

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: JUN 10 2016

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 4/13/16
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WALKER, PATRICIA A
Employee/Petitioner

Case# **11WC008621**

IL DEPT OF HUMAN SERVICES
Employer/Respondent

16IWCC0387

On 5/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

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

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

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

1745 CMS - RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAY 20 2015

GERALD A. RAGGIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0387

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

PATRICIA A. WALKER
Employee/Petitioner

v.

ILLINOIS DEPT. OF HUMAN SERVICES
Employer/Respondent

Case # **11** WC **8621**

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 **D. DOUGLAS McCARTHY**, Arbitrator of the Commission, in the city of **PEORIA**, on **04/14/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **09/20/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**39,780.00**; the average weekly wage was $**765.00**.

On the date of accident, Petitioner was **63** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

THE PETITIONER HAS SUSTAINED THE PERMANENT PARTIAL DISABILITY TO THE EXTENT OF 15 % LOSS OF USE OF THE RIGHT HAND REPRESENTING 30.75 WEEKS OF DISABILITY AND 12.5% LOSS OF USE OF THE LEFT HAND REPRESENTING 25.625 WEEKS OF DISABILITY USING A PPD RATE OF $459.00 PURSUANT TO SECTION 8(E) OF THE ACT.

THE RESPONDENT IS LIABLE FOR REIMBURSEMENT TO MEDICARE FOR THE CONDITIONAL PAYMENTS MADE FOR THE PETITIONER'S CARPAL TUNNEL SURGERIES IN THE AMOUNT OF $3,844.30.

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

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

May 15, 2015
Date

MAY 20 2015

16IWCC0387

PATRICIA A. WALKER)
)
v.) Case # 11 WC 8621
)
ILLINOIS DEPT. OF HUMAN SERVICES)

IN SUPPORT OF THE ARBITRATOR'S MEMORANDUM OF DECISION, THE ARBITRATOR MAKES FINDINGS REGARDING THE FOLLOWING ISSUES:

- C. Did an accident occur that arose out of an in the course of Petitioner's employment by Respondent?
- E. Was timely notice of the accident given to Respondent?
- F. Is the petitioner's present condition of ill-being causally related to the injury?
- J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
- L. What is the nature and extent of the injury?

Statement of Facts

Petitioner is 68 years old and retired from the State of Illinois. Petitioner worked for the Illinois Department of Human Services from 1996 through November 2012. Petitioner worked in Peoria until 2002 and the Pekin IDHS office from 2002 through 2012.

Petitioner's last day worked was June 6, 2010. Petitioner took medical leave for unrelated condition to her knees. Petitioner never returned to work after taking the medical leave on June 6, 2010.

Petitioner's job was a clerk typist/office assistant. Petitioner worked at the front desk in Peoria and Pekin. Petitioner did initial intake with each client. Petitioner estimated that she handled approximately 300 to 500 cases per day in Peoria and 75 to 200 in Pekin. Each intake required a few minutes of data entry. She would type the person's name and request into the computer. Then she would enter the name of the person being seen. She would type three to four sentences commenting on the customer's request. She also did smaller jobs on Saturdays, typing names and numbers onto a spread sheet.

Petitioner testified that she spent over 50% of her time performing data entry. This testimony is consistent with the volume of clients that she was seeing on average in Peoria and Pekin. Petitioner testified that her other duties included answering the phone, filing, and other related paperwork duties.

Respondent introduced into evidence a job description (Respondent's exhibit #5). The demands of the job state that she uses her hands for typing and good finger dexterity 4 to 6 hours per day. This job description is consistent with Petitioner's testimony

Petitioner demonstrated for the Arbitrator how she entered data on the computer. Petitioner testified that she rested her wrists on the desk with her hands in an extended position. Petitioner testified that she always performed data entry with her hands resting on a hard table at both offices.

Respondent did not offer any evidence to rebut the description of Petitioner's job duties nor the manner in which she performed her job duties.

Respondent disputed notice in this matter. Petitioner testified that she filled out the CMS Workers' Compensation Employees Notice of Injury form on October 26, 2010. Petitioner testified that she took that to the Pekin Administrative office on that date. Petitioner testified that Cheryl Schlobohm was on leave for a medical condition and the Notice of Injury form was turned into Sue Benny. Sue Benny was another administrator at the Pekin office. This testimony is not rebutted.

Respondent turned in multiple forms from CMS which suggested that the State was not provided notice of this injury until June 16, 2011 based upon received stamps on the paperwork. Respondent did not call a witness with personal knowledge of when those documents were actually stamped. Respondent did not call the person who stamped the documents.

Respondent called Kelly Lynch (nee Lanane) to testify. Kelly Lynch was an area supervisor. She was not Petitioner's direct supervisor, nor was she working at the Tazewell office in October 2010. Kelly Lynch began working in the Pekin office in 2011 and never worked with the Petitioner. She said she first learned of the claim on June 15, 2011, when she was contacted by Ms. Schlobohm.

Respondent's attorney requested that the arbitration hearing be bifurcated for an additional day of testimony so he could present Ms.Schlobohm as a witness. The Arbitrator granted the request. On the next morning, Respondent's attorney reported to the Arbitrator that Ms. Schlobohm would not be appearing to testify, and elected to rest his case. As stated above, the Petitioner testified that she reported the claim to Ms. Benny in Pekin on October 26, 2010 as Ms. Schlobohm was not at work on that date. In light of Ms. Schlobohm's failure to appear, the Petitioner's testimony on notice is unrebutted.

Additionally, Respondent's denial of notice of the injury until June 2011 is rebutted by the fact that Petitioner filed an Application for Adjustment of Claim on March 1, 2011 with proof of service to the workers' compensation division of the Illinois Department Human Services on that date.

On September 20, 2010 Petitioner sought care with her family physician at Unity Point Methodist for bilateral hand numbness. She was diagnosed with, among other things, carpal tunnel syndrome. She was seen again on December 16, 2010 with similar complaints. She said that she had been wearing a wrist brace. She was diagnosed with bilateral carpal tunnel syndrome, and an order was entered to refer her to an orthopedist. Petitioner was eventually referred to orthopedic surgeon Dr. Don Mitzelfelt. On February 17, 2011 Dr. Mitzelfelt examined Petitioner and suspected bilateral carpal tunnel syndrome. Dr. Mitzelfelt requested an EMG. The EMG was performed on March 1, 2011 at IMPR.

Petitioner provided IPMR with a history of 3 year duration of progressive numbness and tingling in her hands related to work. Petitioner tried splints which only improved nocturnal symptoms. Petitioner reported that she continued to have significant numbness and tingling in the left greater than right. The EMG revealed mild to moderate bilateral carpal tunnel.

On March 31, 2011 Petitioner underwent left carpal tunnel surgery. On May 17, 2012 Petitioner underwent right carpal tunnel surgery. Petitioner testified that her recovery from her right carpal tunnel was worse than compared to the left.

Petitioner was released by Dr. Mitzelfelt without restrictions. Petitioner testified that her numbness and tingling improved. Petitioner continues to experience residual periodic numbness and tingling in both hands depending on activities such as gardening. Petitioner testified that her grip is weaker in her hands as a result of her carpal tunnel. She relates dropping items and having difficulty lifting household things such as coffee cups, pots or pans. Petitioner has not sought medical treatment for her carpal tunnel syndrome since 2012.

At this time Petitioner is retired and has no further plans of returning to the workforce.

On October 19, 2011 Petitioner was examined at the request of the Respondent by Dr. James Williams. Petitioner testified that she gave Dr. Williams a description of her general job duties. Petitioner testified that she was not asked nor did she demonstrate the manner in which she positioned her hands while performing data entry. Additionally, Petitioner was not asked if she rested her wrists on a hard surface while typing. Dr. Williams examined Petitioner after her left carpal tunnel surgery, but before her right carpal tunnel release. Dr. Williams has not examined Petitioner since her right carpal tunnel surgery.

Dr. Williams and Dr. Mitzelfelt both provided testimony in this matter. Dr. Mitzelfelt was provided with a hypothetical regarding Petitioner's work duties. The hypothetical included Petitioner stopping work in June 2010 and continuing to have numbness and tingling in her hands. Dr. Mitzelfelt was informed that Petitioner worked for the State of Illinois for over 20 years and typed a majority of the day with her wrists

resting on a hard surface while keyboarding. Based upon these factors, Dr. Mitzelfelt testified that carpal tunnel is definitely an aggravating factor.

Dr. Mitzelfelt was asked about Petitioner's symptoms not improving after stopping work. Dr. Mitzelfelt testified that age is a factor in this regard. Based upon Petitioner's being older, it is less likely that the carpal tunnel would spontaneously resolve with cessation of the inciting work activity. Dr. Mitzelfelt testified that younger workers with carpal tunnel can change jobs or quit jobs and resolve carpal tunnel by stopping the repetitive aggravating activity.

Dr. Mitzelfelt testified that flexion and extension of the wrist increases the pressure over the median nerve and has been linked to the development of carpal tunnel syndrome when the flexion and extension occurs on a repetitive basis. Dr. Mitzelfelt testified that resting wrists on a hard surface while keyboarding can contribute to carpal tunnel because it increases the pressure anteriorly over the median nerve.

Dr. Williams provided testimony in this matter. Dr. Williams concluded that Petitioner's work activities would not have aggravated or caused her bilateral carpal tunnel. This was based upon Dr. Williams understanding of Petitioner's job duties. Dr. Williams testified that Petitioner's typing was intermittent. This is contradicted by Petitioner's testimony and the Respondent's job description which showed Petitioner's typing frequency. Dr. Williams also testified that Petitioner's lack of symptom improvement after quitting working was an indication that her work activities were not contributing to her symptoms.

On cross examination Dr. Williams testified that he did not receive any additional records since October 19, 2011 including the right carpal tunnel operative report. Dr. Williams testified that he was not provided a specific percentage of time that Petitioner was typing each day. Dr. Williams had no criticisms of Dr. Mitzelfelt. In regards to Dr. Mitzelfelt's testimony regarding younger people stopping work, Dr. Williams testified that it is possible that an older person would not notice a lessening of symptoms when stopping work due to age. Dr. Williams testified that work splints are used to put a patient's wrist in a neutral position and reduce the pressure over the median nerve. Dr. Williams explained that it is pressure over the median nerve that causes a mechanical or a vascular effect on the median nerve. In regards to ergonomics Dr. Williams testified that if Petitioner was resting her wrist on a hard surface while typing that the direct pressure over the median nerve could possibly contribute or aggravate Petitioner's carpal tunnel syndrome.

In terms of other risk factors for carpal tunnel, Petitioner is female and has hypertension, but there is no evidence of the Petitioner having rheumatoid arthritis, diabetes, or thyroid problems. Dr. Williams testified that neither fibromyalgia nor osteoarthritis play a role in development of carpal tunnel symptoms.

Both doctors testified that Petitioner's treatment for bilateral carpal tunnel to include surgery was reasonable and necessary.

Petitioner introduced into evidence conditional payment log from Medicare indicating conditional payments by Medicare for Petitioner's bilateral carpal tunnel syndrome in the amount of $3,844.30. Respondent objected to liability for these bills.

Conclusions of Law

1. The Arbitrator finds that the Petitioner provided notice to the Respondent. Petitioner testified that she turned in the Notice of Injury form on October 26, 2010 to Sue Benny, with said form being introduced into evidence as Respondent's Exhibit 2. Petitioner's testimony is not rebutted.

2. The Arbitrator finds that the Petitioner's bilateral carpal tunnel syndrome and bilateral carpal tunnel releases are causally related to her work duties. The Arbitrator's opinion is based upon Petitioner keyboarding a majority of the day with her wrist resting on a hard surface in an extended position. Dr. Williams did not have information regarding the specific times that Petitioner keyboarded. Dr. Williams mistakenly believed that Petitioner was keyboarding on an intermittent basis. This assumption is contradicted by Petitioner's testimony and Respondent's job description. Finally, Dr. Mitzelfelt testified that the act of keyboarding, especially with resting the wrist on a hard surface would definitely aggravate carpal tunnel syndrome. Dr. Williams testified that typing while resting wrists on a hard surface could possibly aggravate carpal tunnel syndrome.

3. Petitioner introduced into evidence conditional payments by Medicare in the amount of $3,844.30 for Petitioner's bilateral carpal tunnel surgeries. Respondent is found liable for the same. Both Dr. Williams and Dr. Mitzelfelt both testified that the treatment to include surgery was reasonable and necessary for Petitioner.

4. In regards to permanent partial disability, the Arbitrator finds that the condition in Petitioner's both hands are permanent. Petitioner has had a good recovery. This case is pre-September 2011. Petitioner is retired from employment. Petitioner has residual periodic numbness in both hands and reduced grip strength. Petitioner testified that her right hand is worse than her left. Based upon the evidence and Petitioner's testimony, the Arbitrator finds that the Petitioner sustained a permanent partial disability of 15% to the right hand and 12.5% of the left hand pursuant to Section 8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Foy,
Petitioner,

vs. NO: 14WC 42464

North American Lighting,
Respondent,

16IWCC0388

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 29, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 10 2016
o040716
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen J. Mathis

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FOY, DAVID
Employee/Petitioner

Case# **14WC042464**

14WC042463

NORTH AMERICAN LIGHTING
Employer/Respondent

16IWCC0388

On 9/29/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0157 ASHER & SMITH
DREW P GRIFFIN
1119 N MAIN ST PO BOX 340
PARIS, IL 61944

0445 RODDY LAW LTD
STEPHEN A CARTER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

16IWCC0388

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

DAVID FOY
Employee/Petitioner

v.

NORTH AMERICAN LIGHTING
Employer/Respondent

Case # **14** WC **42464**

Consolidated cases: **14 WC 42463**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **August 14, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 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*** 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 $**34,082.36**; the average weekly wage was $**655.43**.

On the date of accident, Petitioner was **48** 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 $**3558.01** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**3558.01**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $393.26 /week for 32.25 weeks because the injury sustained caused 15% loss of use of right leg, as provided in Section 8(e)(12) of the Act.

Respondent shall pay the Petitioner temporary total disability benefits from November 19, 2014 through January 18, 2015, a period of 8 5/7 weeks, at a rate of $436.95 per week.

Respondent shall pay the amount of $912.00 for necessary medical services that were provided to Petitioner as a result of this accidental injury, pursuant to the Fee Schedule (Petitioner's Exhibit 20).

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

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

D. Dylan McCarthy
Signature of Arbitrator

Sept. 22, 2015
Date

SEP 29 2015

FINDINGS OF FACT:

The parties in this matter stipulated that on October 6, 2014, Petitioner and Respondent were operating under the Illinois Workers' Compensation Act and that their relationship was one of employee and employer. The Parties further agreed orally at the hearing that at least three medical bills known to Petitioner at this time and related to this accident remain unpaid, and the parties stipulated that Respondent would pay said unpaid medical bills if found liable for the claim. The balance sheet that was admitted into evidence as Petitioner's Exhibit 20 shows these unpaid amounts from the dates of 12/29/14, 1/8/15, and 1/29/15 total $912.00. (PX 20) This case was tried in consolidation with 14 WC 42463. As the Arbitrator stated at trial, the Petitioner's exhibits would be and have been renumbered to reflect the fact that one set of exhibits were used for both claims. Virtually all issues in this case were contested, as well as whether the Respondent is entitled to any credit for a prior settlement received by the Petitioner in the State of Florida.

The Petitioner, David Foy (hereinafter "Petitioner"), testified that he had been an employee of Respondent since approximately November 2013. Petitioner further testified that on October 6, 2014, the date of the accident, his job description was that of "material handler." Respondent's company primarily produces lights, including headlights for automobiles. Petitioner testified that his job as material handler required him to transport various types of product necessary to the manufacturing process to various parts of Respondent's facility. Petitioner testified that he would transport this product with the aid of what he referred to as "rollers." From Petitioner's testimony, it seems that a roller is akin to some form of handcart: a sort of platform on wheels upon which product could be loaded and then pushed by an employee. Petitioner testified that he did not operate a forklift to move the product—he actually had to load the product onto the roller and then use his own physical capabilities to move the product. Petitioner currently is still an employee of Respondent, and he continues to work as a material handler.

On October 6, 2014, Petitioner testified that while engaged in his employment, he tried to push a skid containing some form of materials out of his way so he could continue his path of transporting other material. Petitioner testified that as he pushed the skid, he extended his right leg behind him. On the second push, he felt a sharp pop in his knee. He further explained that the pain he experienced was so sensational and intense that it brought him to the ground.

Petitioner testified that after being helped up by one of his supervisors, he promptly filled out a written accident report. The history on the accident report is consistent with the history he explained at arbitration. (PX 20)

Petitioner then testified that he was taken to Paris Community Hospital in Paris, Illinois, and this testimony is confirmed by report from Paris Community Hospital. (RX 4) The report shows as a history from the Petitioner that his injury occurred at work while trying to "push" a box. His examination showed a decrease of range of motion with pain. The diagnosis was that of a knee sprain.

On October 7, 2014, according to a record in evidence, Petitioner presented to the occupational medicine clinic complaining of the pain he was experiencing from the accident the day prior. (RX 5) Petitioner's explanation of the way the accident occurred as recorded in this document (RX 5) substantially matches what he testified to and what he printed by hand and signed on the Accident Report he completed at work immediately following the accident. He said that he was pushing carts and had a sudden pop in the right knee. His examination on that date showed edema of the right knee into the calf, with noted effusion and a limited range of motion. He was diagnosed with a knee injury with possible ligament involvement, and an MRI was recommended.

On October 30, 2014, Petitioner had his first appointment with Dr. Madsen, an orthopedic surgeon. (PX 15) At this appointment, Dr. Madsen's report indicated that Petitioner explained how he sustained his injury, which, again, was substantially the same explanation that Petitioner had previously testified to and reported on the Accident Report. According to the medical report, Petitioner presented to the Dr. Madsen that the pain was "constant" and "achy, sharp, and burning in quality" and that it was elevated in the mornings. Dr. Madsen's physical examination noted effusion and lack of full extension. Dr. Madsen ordered that Petitioner have an MRI performed and a follow up appointment scheduled. Dr. Madsen did allow the Petitioner to return to work, but restricted him to clerical duty only. The initial diagnosis from Dr. Madsen was right knee internal derangement. (PX 15)

The MRI was performed on November 6, 2014. The Petitioner was found to have tricompartmental arthritis, a tear of the posterior horn of the medial meniscus and degenerative changes of the lateral meniscus. (PX 18)

Dr. Madsen performed right knee arthroscopy on Petitioner on November 19, 2014. He basically repaired a radial tear of the medial meniscus and smoothed out arthritic areas under the patella and trochlear groove. Dr. Madsen's postoperative diagnosis of the Petitioner was as follows: right knee medial meniscus tear; right knee chondromalacia tibial plateau; right knee chondromalacia patella; and right knee multiple osteochondral loose bodies. (PX 16)

On December 4, 2014, Petitioner followed up with Dr. Madsen. At this follow-up, Dr. Madsen's report indicates that Petitioner told Dr. Madsen that he continued to experience intermittent pain that required him to use crutches and ice, and Petitioner rated the pain as "5/10." (PX 14) Dr. Madsen ordered that the Petitioner was to begin physical therapy and that he was to continue to be off work. (PX 14)

On January 8, 2014, Petitioner again saw Dr. Madsen. (PX 13) In his report, Dr. Madsen noted that Petitioner complained that the pain was "sharp" and that Petitioner rated the pain as "6-7 out of 10 in severity." (PX 13) Upon physical examination, Dr. Madsen noted Petitioner to be in moderate pain, ordered Petitioner to continue physical therapy, and continued to restrict him from returning to work. (PX 13)

The last time Petitioner treated for this injury caused by the accident was on January 29, 2015, when Petitioner had a follow-up appointment with Dr. Madsen. (PX 12) At this appointment, according to Dr. Madsen's report, Petitioner rated the pain he was experiencing in his knee as "7-8 out of 10." His examination showed minimal swelling and pain with flexion and extension. Nonetheless, Dr. Madsen returned the Petitioner to full duty work. He further indicated that the Petitioner was at MMI and had an AMA impairment rating of 7 % loss of the leg. He gave no explanation as to how he arrived at that figure.

After his last appointment with Dr. Madsen, Petitioner returned to work and continued in his full-duty capacity. At the hearing, Petitioner testified that his right knee was painful; more so than the left. He said it was particularly painful in the morning and that the pain woke him up at night on occasion.

Prior to the accident, the Petitioner testified that he'd injured the knee in Florida and that he had surgery. He said that following the surgery, his knee felt good and he returned back to normal. On cross-examination, he acknowledged that he did complain to Dr. Madsen of right knee pain prior to his accident while he was recovering from left knee surgery. He said that it did hurt from walking on it at that time, and that he had little pains in the knee in October prior to his accident.

Medical records of the Florida injury were admitted into evidence. They show treatment by Dr. Boneberger for both knees between February 18 and November 12 of 2010. (RX 7) Surgery was performed on May 3, 2010, and the operative report showed a tear of the posterior medial meniscus, Grade 4 cartilage loss of the medial femoral condyle, Grade 1 softening of the trochlea and chondromalacia of the patella. After therapy, Dr. Boneberger noted at his last examination that the Petitioner had a normal range of motion. He gave him no restrictions and assigned an impairment rating without explanation of 3 % of the leg.

Respondent offered additional records, which were admitted. The records were offered in connection with a settlement and claimed credit, and they are summarized in the conclusions of law.

CONCLUSIONS OF LAW:

Based on the evidence presented at arbitration, the Arbitrator concludes that the Petitioner did establish that he sustained an accidental injury that arose out of and in the course of his employment by Respondent. The arbitrator finds that notice of the accident was provided to Respondent within the time limits of the Act. In fact, based on the exhibits of the parties, (PX 20 & RX 12), the Arbitrator is unsure why notice was not stipulated to by the Respondent. The Arbitrator further finds that Petitioner has demonstrated through his uncontroverted testimony that his accidental injury was causally connected to his current condition of ill-being.

While the Petitioner did have pre-existing injury to the right knee which was apparent on the x-ray's done on the date of accident, he had no record of treatment after his release in Florida in November 2010. He worked for the respondent in a fairly heavy duty job as a material handler from November 18, 2013 until injuring his left knee the following March. Again, no evidence was admitted to show he had any ongoing problems prior to that injury. Following his left knee surgery, he did experience some pain in the right knee and did once ask Dr. Madsen for treatment in July 2014. However, he testified to a clear traumatic event on October 6, 2014 while pushing a skid, and he gave consistent histories on his accident report, the emergency room, the occupational nurse practitioner and Dr. Madsen.

In addition, all of the examinations during the first week following the accident show findings consistent with an acute injury. There were no gaps in treatment. Dr. Madsen performed surgery just six weeks following the accident, and in surgery found a radial tear of the medial meniscus. The Arbitrator notes the operative report from Florida, and notes that after the right medial meniscus was repaired, Dr. Bonenberger found the remainder of the meniscus to be stable. (RX 7)

The Petitioner was asked by the Respondent's attorney if he had told the insurance claims representative that he hurt his right knee by overcompensating for the left, but he said he didn't recall the conversation. No evidence was offered by the Respondent to prove that the conversation had occurred, nor when it occurred. Even if he did had some right knee pain from overcompensation when he was recovering from his left knee surgery, it would not be evidence sufficient to overcome the evidence of acute trauma on October 6.

As the Arbitrator has found in the Petitioner's favor on accident and causal connection, the Petitioner is also entitled to TTD benefits for the periods claimed along with medical subject to the Fee Schedule.

Respondent argues that it is entitled to a credit against whatever award the Arbitrator may order in this matter. This argument is based on the allegation that Petitioner has previously had a

permanent partial loss to the same member that Petitioner has injured in this matter and that Petitioner was compensated for this alleged loss in an out-of-state workers' compensation action in the state of Florida. In support of its argument, Respondent introduced into evidence some of Petitioner's medical records from the state of Florida from around 2010 (RX 7) and documentation related to a settlement Petitioner received in Florida that same year. (RX 16) Further, Respondent introduced into evidence the case of Keil v. Industrial Comm'n, 331 Ill.App.3d 478 (3d Dist. 2002) in support of its position. (RX 17)

The Illinois Workers' Compensation Act states as follows:

> "In computing the compensation to be paid to any employee who, before the accident for which he claims compensation, had before that time sustained an injury resulting in the loss by amputation or partial loss by amputation of any member, including hand, arm, thumb or fingers, leg, foot or any toes, such loss or partial loss of any such member shall be deducted from any award made for the subsequent injury. For the permanent loss of use or the permanent partial loss of use of any such member or the partial loss of sight of an eye, for which compensation has been paid, then such loss shall be taken into consideration and deducted from any award for the subsequent injury."

820 ILCS 305/8 (e)(17).

At trial, Petitioner testified that he had previously had a workers' compensation claim in Florida. Petitioner testified that his prior Florida workers' compensation matter concluded when a settlement had been reached. Petitioner testified that the net payment he received from settlement was approximately $30,000.00. However, Petitioner testified that he had no knowledge of what the settlement was based on, as well as the fact that he had no knowledge of exactly what he was being compensated for.

Respondent entered into evidence several documents, all with substantially the same heading: "State of Florida, Division of Administrative Hearings, Office of the Judges of Compensation Claims, Daytona Beach District Office." (RX 16) The Arbitrator believes that the total amount of Petitioner's prior out-of-state settlement can be ascertained from the document entitled, "Motion for Approval of Attorney's Fee and Allocation of Child Support Arrearage for Settlements under Section 440.20(11)(c),(d) and (e) Florida Statutes." That Motion recites a settlement amount of $35,000.00. (RX 16)

The Arbitrator finds this Motion extremely vague with regards to how it relates to Petitioner's Florida workers' compensation case and the partial permanent loss for which Respondent wants a credit. It makes no reference to any specific work-related injury; it does not discuss any injured body part(s) or the extent of any injury thereto; it does not indicate how the settlement amount is compensation for any loss experienced by Petitioner. In short, this Motion contains none of the type of information that a settlement contract or decision from this State for a workers' compensation claim would contain. What's more, this document is styled as a motion, and it appears only to seek court approval of an attorney's fee and some amount of funds related to "child support arrearage allocation." (RX 16)

The only Florida document presented by the Respondent that is an order, "Order Under Section 440.201(11)(c),(d),(e). Florida Statues. (2003)" appears to simply approve the attorney's fee and "child support arrearage allocation" requested in the aforementioned Motion. (RX 16) The Order does not actually approve any settlement. It does not discuss any injury to the any part of the Petitioner's body and the subsequent loss Petitioner suffered. It does not explain what link there may be between the settlement that the parties had entered into independently (that apparently is not subject to court approval in Florida) and any loss that may have been sustained by the Petitioner as a result of his work injury.

The Arbitrator finds that none of these court documents from Florida indicate the type of permanent partial loss sustained by the Petitioner or the extent of whatever that loss might be. In addition, these documents do not explain if or how the compensation provided to Petitioner under this Florida settlement was compensation for any partial loss of any member of the Petitioner's body that was a result of an injury compensable under the workers' compensation laws in the state of Florida.

The respondent points to the case of Keil v. Industrial Comm'n, 331 Ill.App.3d 478 (3d Dist. 2002). In Keil, the issue presented was whether the Commission had the authority under 8(e)(17) of the Illinois Workers' Compensation Act to grant a credit to an employer for a prior out-of-state award based on a loss for which the employee had previously been compensated. Keil, 331 Ill.App.3d at 479. The employee in that case, Gary Keil, prior to seeking benefits under the Illinois Workers' Compensation Act, had been awarded a 17-1/2 percent loss of use of his right leg in an Iowa workers' compensation case that resulted in him receiving $21,000.00 in compensation. Id.

Ultimately, the Keil court held that, "the Commission *may* grant credit for out-of-state awards pursuant to section 8(e)(17)." Id. at 481 (emphasis added). However, the court stated that, "the manner in which the amount of credit is determined is a factual matter for the Commission." Id. The court reasoned that this would allow for the requisite amount of flexibility for the Commission to address issues of whether to grant credit for out-of-state awards on a case-by-case basis, thereby helping to achieve the purpose of the Act. Id.

It is well settled that the party claiming the credit, in this case the Respondent, has the burden of proving entitlement to said credit. In the instant matter, there has been no evidence presented that indicates the nature and extent of any alleged prior permanent partial loss to a member of the Petitioner, nor was there any evidence as to how this alleged loss may have been compensated. Respondent wants the Arbitrator to look at the amount of the Florida settlement, examine a few select medical records, and then determine that, based on the dollar amount of settlement, Petitioner was compensated for some significant level of prior permanent partial loss for which Respondent should receive a credit. The Arbitrator cannot do this.

The Florida documents make no mention of any type of loss to Petitioner's member(s). Not only are the documents silent as to loss, but also the Arbitrator recognizes that there are many other factors that could have influenced the negotiation between the parties that allowed them to arrive at that settlement figure they did. For example, based on the fact that Petitioner ceased work for the employer as soon as the settlement was paid, the Arbitrator easily could presume that a significant portion of the settlement was not compensation for the loss Petitioner actually sustained, but rather for Petitioner ceasing his employment with that employer. Another example would be that a large portion of the compensation could be for medical expenses or for what our state would call TTD. Again, this is just speculation, but it underscores the Arbitrator's point: there is no way to ascertain based on the evidence whether the Petitioner had sustained a prior loss for which he was actually compensated.

Moreover, Petitioner testified that after being treated in Florida, his knees felt just fine. Petitioner stated that he was not experiencing any type of notable pain when he left Florida, and he further testified that his knee was free of any notable pain or disability when he commenced work for Respondent.

There is no way to know, based on the evidence, whether Petitioner suffered a prior permanent partial loss in Florida for which he was compensated, and, if so, what the extent of that loss or compensation for that loss was. Therefore, the arbitrator finds that, after appropriate consideration, no credit will be awarded to Respondent as it had requested in this matter.

With respect to nature and extent of disability, the Arbitrator must look to the five factors referenced by Section 8.1b of the Act.

The only evidence offered by either party concerning the AMA 6th edition are the conclusory comments of Dr. Madsen. As they are not accompanied by any explanation as to how the doctor arrived at his number, they are not given any weight by the Arbitrator.

The Petitioner was 48 years old when he was injured; he worked as a material handler, a job which required him to be on his feet moving materials around the plant with climbing and bending as needed and he was released to full duty work. The Arbitrator finds the age to be rather neutral; the occupation favoring the Petitioner's claim of disability and there was no showing of a future wage loss.

His objective findings from Dr. Madsen at his last visit on January 29, 2015 are noted above.

Based upon all of the above factors, the Arbitrator awards the Petitioner 15 % loss of use of the left leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bradley Wildermuth,

Petitioner,

vs. NO: 13 WC 09536

16IWCC0389

ABF Freight,

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, causal connection, vocational rehabilitation, and 19(d) suspension of 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 August, 28, 2015 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1.00. 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: JUN 13 2016

MB/mam
o:5/19/26
43

Mario Basurto

David L. Gore

Stephen Mathis

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

WILDERMUTH, BRADLEY
Employee/Petitioner

Case# **13WC009536**

ABF FREIGHT
Employer/Respondent

16IWCC0389

On 8/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.20% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1874 AMES LAW OFFICES
STEVEN AMES
1000 THIRD ST PO BOX 55
ORION, IL 61273

2965 KEEFE CAMPBELL BIERY & ASSOC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

16IWCC0389

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
SECTION 19 (B)

Bradley Wildermuth
Employee/Petitioner

v.

ABF Freight
Employer/Respondent

Case # 13 WC 9536

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of Bloomington, on **June 30, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☐ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Vocational Rehabilitation, Determination under Section 25.5**

FINDINGS

On 1/9/12, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

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

Petitioner's current condition of ill-being is causally related to these accidents.

In the year preceding the injury, Petitioner earned $**36,604.88**; the average weekly wage was $**703.94.**

On the date of these accidents, Petitioner was **45** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**42,001.46** for TTD, $**0.00**for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**42,001.46.**

ORDER

The Arbitrator finds the Petitioner's current condition of ill being is causally related to his accident.

The Respondent has paid temporary total disability in the proper amount and the proper time frame by the evidence in this case.

Respondent is order to provide vocational rehabilitation benefits to the Petitioner, beginning with a vocational assessment as described in Commission Rule 7110.10 (a).

Respondent is ordered to pay maintenance benefits in the amount of $469.29/week beginning May 15, 2015.

Petitioner has not committed fraud as described in Section 25.5 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.

D. Dylan McCarthy
Signature of Arbitrator

August 21, 2015
Date

AUG 28 2015

Brad Wildermuth v. ABF Freight Systems Inc.
07 WC 51489

16IWCC0389

The Arbitrator finds the following facts:

Petitioner worked accident-free as a truck driver for respondent, ABF Freight Systems Inc., for about 12 months prior to his January 9, 2012 accident. He testified his duties included driving a semi, hooking up and unhooking trailers and loading/unloading freight.

Petitioner testified that he is right hand dominant, and he never had a hand or finger injury prior to his employment with respondent. Petitioner said that on January 9, 2012 he was loading a trailer when a two wheel hand truck struck his right index finger. There were no witnesses, but he immediately contacted his supervisor, Scott.

Petitioner testified he saw Genesis Immediate care that day, had negative finger x-rays, and was given a splint and Ibuprofen. The following day he saw Genesis Occupational Health and was eventually referred to Dr. Connolly at Orthopedic and Rheumatology Associates, who told him nothing could be done surgically to improve his finger pain. He was also referred to Hammond Henry Physical Therapy. (Pet. Ex 1).

Petitioner testified that he was then referred by his family physician, Dr. Evan Kvelland, to Dr. Tyson Cobb of Orthopedic Specialists, who on 6-11-12 performed a right index MP joint arthroscopic synovectomy with debridement surgery. (Pet. Ex 3). He then saw Kewanee Hospital Physical Therapy. (Pet. Ex 4).

On 2-28-13 Dr. Cobb recommended a fusion of the right index MP joint to resolve intractable pain. (Pet. Ex 3). As noted in that record and in his testimony, petitioner immediately objected to a fusion because of a preexisting anxiety disorder which would make having his finger fixed in an extended position psychologically unbearable. He saw Dr. Kvelland who referred him for treatment to Bridgeway where he saw a social worker and a psychiatrist. (Pet. Ex 6).

Petitioner's independent examining psychologist, Richard Hutchison, Ph.D., testified that he diagnosed petitioner with:

> ... a panic disorder with agoraphobia. That means particularly he can't stand to be enclosed in small spaces kind of a thing. And then obsessive compulsive disorder. That relates to all of that counting and having to have the shower curtain right and the drawers right and wanting to straighten my pictures in my reception room, stuff like that. And then major depressive disorder, recurrent, of moderate degree. And that means that he has got a severe depression that seems to recur and has been there for quite a while. (Pet. Ex. 11, Hutchison Dep. 19:18-20:4).

Dr. Hutchison opined:

> ... based on his psychological state, the fusion and casting of his finger would probably overwhelm him psychologically and lead to a significant deterioration in his mental status. And so ... it's

> highly doubtful that in his current emotional state he would be able to comply with having the fusion surgery. (Pet. Ex. 11, Hutchison Dep. 22:20-23:1).

On 9-4-13 Dr. Cobb assessed petitioner as status post right index finger MP joint arthroscopy and evaluation of ulnar and collateral ligaments with synovectomy with persistent progressive symptoms and more significant dorsal swelling over the last month; stenosing tenosynovitis with no catching, clicking or locking; and "severe anxiety, preventing immobilization or fusion." He referred petitioner for an FCE. (Pet. Ex. 3). On 9-17-13, petitioner demanded vocational rehabilitation with maintenance and filed a petition for same. (Pet. Ex. 7).

On cross examination in his deposition, Dr. Cobb testified, "[petitioner's] anxiety with immobilization puts him at significant risk of having some kind of a bad outcome or complication during the early postoperative period should he rip off his immobilization during an anxiety attack in the middle of the night or something." (Pet. Ex. 10, Cobb Dep. 33:6-22).

On 12-10-13 petitioner underwent an FCE at Kewanee Physical Therapy, which the therapist deemed to have an invalid result. (Pet. Ex. 10 11:2-17, ex. 3 to the deposition). Petitioner then underwent a 2-13-14 FCE at Rock Valley Physical Therapy with a valid result. His permanent work restrictions were 20# lifting floor to waist, 20# lifting waist to shoulder, 20# carry with two hands thirty feet, 10# 1 hand carry thirty feet, and 60# pushing or pulling thirty feet. (Pet. Ex. 10, ex. 2 to the deposition). Dr. Cobb concurred with those restrictions, per his 4-1-14 letter and his 5-1-15 deposition (Pet. Ex. 10 11:2-17; ex. 5 to the deposition). Dr. Cobb said the restrictions were appropriate because, "[a]nytime he loads the MP joint or makes a fist or grasps with the fist, it's going to activate and load that joint and create pain." (Pet. Ex. 10, Cobb Dep. 12:1-6).

Dr. Cobb said the Rock Valley Physical Therapy FCE was more appropriate for setting permanent restrictions than the Kewanee Hospital Physical Therapy FCE, because he "tend[ed] to ignore FCE's when a patient's failed a validity testing because it suggests that it's not an accurate assessment." (Pet. Ex. 10, Cobb Dep. 12:21-13:1). So far as understanding why petitioner may have had an invalid FCE the first time around, Dr. Cobb testified:

> Well, if they're having significant pain, it's going to cause them to self-limit. So, you know, I think it's -- in the setting where a patient's having a lot of acute pain -- and, you know, I don't know what was happening the day that he had his test, but we could speculate that maybe his flexor sheath was inflamed and with more of the trigger finger appearance that I saw at one time and that Dr. Vender indicates. And if that were true, then, you know, after a single attempt of trying to grip and having substantial, sharp pain, one tends to self-limit and to simply -- just self-preservation, if you will." (Pet. Ex. 10, Cobb Dep. 13:2-17).

On cross examination, Dr. Cobb testified the Rock Valley Physical Therapy therapist who conducted the second FCE, of 2-13-14, was Greg Monson, who the doctor said "is an experienced therapist, and .. does a good job. ... I've seen a lot of his reports ...." (Pet. Ex. 10, Cobb Dep. 29:24-30:1-8).

Dr. Michael Vender, respondent's independent examining physician, said petitioner's 51.7 percent validity finding on his first FCE indicated "lack of motivation in trying to determine whether he could return to work." (Resp. Dep. Dr. Vender 21:12-17). Dr. Vender testified:

> ... functional capacity evaluations are very misleading. It is not uncommon for them to underestimate somebody's work capabilities, which may have to do with patient motivation or just the interpretation of the study or how the study was done. Also on the opposite end it can overestimate somebody's work capabilities. So they are -- they are just not very objective. Too much subjective -- subjectivity to them. In this particular case it is not necessary because we know what the functional deficits are. It is not someone who had multiple injuries to the hand where things don't move, the wrist is stiff, the fingers are stiff, maybe one finger is missing. In those cases it sometimes could be hard to assess exactly what the function loss is and how it is going to impact on different activities. In this case we know what's wrong with the hand. It's relatively straightforward. It doesn't take much more than common sense to be able to figure out what you can and can't do. (Resp. Dep. Dr. Vender 18:3-19:6).

On cross examination, Dr. Vender admitted portions of his physical examination of petitioner were subjective like FCE's, saying, "I'm actually giving him the benefit of the doubt when I say it's unstable and tender. I'm giving him the benefit of the doubt that there is something wrong. So while there is subjectivity to it, I am giving him the fact that I think it's abnormal." (Resp. Dep. Dr. Vender 32:13-24).

On cross examination, Dr. Cobb testified that with the use of a splint "there may be some aspects of his functional abilities that would be enhanced with the splint, and at the same time, some of them might be inhibited because the splint's going to limit motion. (Pet. Ex. 10, Cobb Dep. 21:11-17). He testified that if petitioner underwent the prescribed fusion, "I suspect we could increase his function if we could get a stable fusion. If, on the other hand, we operated on him and we wound up with a nonunion because he had some type of an anxiety-related event and tore his immobilization off in the middle of the night shortly after surgery, then we could wind up with a situation that's infinitely worse than what it currently is." (Pet. Ex. 10, Cobb Dep. 14:13-25).

Dr. Vender opined that with a fusion, petitioner could return to his old job. (Resp. Dep. Dr. Vender 13:17-21). Dr. Vender recommended a fusion for the MP joint because petitioner "had a painful MP joint and that's one way of making it not painful." (Resp. Dep. Dr. Vender 30:17-20).

Petitioner testified he is currently unable to do his former job for respondent as a truck driver because of all the tasks which require him to use his right hand to squeeze, lift, push and pull, all of which would not only be beyond his restrictions, but would cause serious and chronic pain. He listed things he could no longer do at home, such as play baseball or football with his son. He stated on redirect that he could grasp a broom, but not tightly with his right hand. Moreover, he admitted that he did try to carry on his activities at home as best he could with his limitations. Yet, every time he used his right hand he paid for it with pain and swelling, being kept up at night with the pain. He said he had trained his left hand to do ordinary things, like brush his teeth, because such minimal movements hurt his right index finger.

Petitioner testified to the job search he had performed from May 15, 2015 through June 26, 2015, consisting of 27 employers and positions, both in the trucking industry and without. (Pet. Ex. 8). Specifically, he applied for all of the jobs listed in respondent's labor market survey. He testified on cross examination he did not begin his application or interview process by mentioning his restrictions, but as he was asked he told the prospective employer of his restrictions. He failed to receive any offers of employment. In order to assist him in applying for jobs and possibly locating an appropriate field for retraining, he applied for help with the Illinois Department of Human Services' Division of Rehabilitation Services. (Pet. Ex. 9).

Petitioner testified that as of the time of hearing he was seeking vocational rehabilitation provided by respondent to help him prepare for interviewing, to help him find job leads and to help him identify possible marketable fields for which he could retrain. He said he was seeking maintenance.

Dr. Vender opined petitioner could return to work full duty, with or without a splint. (Resp. Dep. Dr. Vender 17:9-15; 38:20-39:1). However, Dr. Vender admitted on cross that petitioner's "condition was serious enough with symptoms that he needed [fusion] surgery, [as of his] February 18th of '13 [IME] all the way up through [his] 3/18/14 [IME], yet it wasn't serious enough that he needed any kind of work restrictions whatsoever." (Resp. Dep. Dr. Vender 39:14-19).

Respondent's rehabilitation consultant, Denice Vogrich, testified she was originally retained by respondent as a medical case manager for petitioner's case. She testified without rebuttal that the Petitioner or his attorney refused her services in that capacity. Later, she was asked by a representative of the employer to create a labor market survey based on the information available in the 2014 IME report by Dr. Vender. On cross examination she admitted that she did not review either of petitioner's FCE's or any other records or materials in preparation of her labor market survey. She testified she included in the survey jobs which petitioner could do if he were able to work full duty without restrictions with intermittent use of a finger splint for more stabilization and comfort. She testified she did not provide vocational rehabilitation services to petitioner because he would not work with her. However, on cross examination, Ms. Vogrich admitted she had not offered vocational rehabilitation services to petitioner, neither orally nor in writing. She said she did not know if petitioner's job search as listed in exhibit 8 was fabricated. However, she did testify on cross examination that petitioner could benefit from her services if they were offered and he accepted them.

Respondent offered surveillance video of petitioner which showed him sweeping snow off a roof with a broom and pushing snow through a gutter with the broom handle. Further, petitioner was shown carrying items with both hands and putting them in a vehicle. Also, he was shown wrapping wire with his left hand around his right while on the roof. Finally, petitioner was shown spraying a car with a pressure washer wand. For most of the video, he used his left hand to operate the handle. Briefly, when spraying inside the driver's door, he used his right hand.

Therefore, the Arbitrator concludes respondent disputes the following issues and finds as follows:

The Respondent raised the issue of causation but did not really put into evidence anything in support of its claim. As is stated below in the discussion concerning fraud, the Petitioner treated on a regular basis with consistent findings concerning his right hand until having his second FCE on February 13, 2014. Even Dr. Vender, the Respondent's IME physician, testified that the accident injured the Petitioner's right second metacarpal joint necessitating the surgery by Dr. Cobb. He further opined that the injury and surgery "... helped lead to the development of the arthritis." (RX 2 at 41) A fusion, said Dr. Vender, was a medically reasonable treatment option. (Id at 30) The Petitioner has not had a fusion due to his psychological condition referenced above, and he is currently left with the symptoms he describes. The accident is causally related to his condition of ill being.

Dr. Cobb basically released the Petitioner at MMI on September 4, 2013, when he recommended an FCE to establish permanent limitations. The initial FCE of December 10, 2013 was deemed invalid. The second valid test came in February, as mentioned above. The Respondent paid TTD benefits from the accident date through December 9, 2013, and the Arbitrator believes that is a fair date for ending those benefits. It does not appear from the evidence that the Petitioner has received any treatment for his right hand since that time.

Section 8(a) of the Act provides that 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) (West 2010). A claimant is generally entitled to vocational rehabilitation when he sustains a work-related injury which causes a reduction in earning power and there is evidence rehabilitation will increase his earning capacity. *National Tea Co. v. Industrial Comm'n,* 97 Ill.2d 424, 432, 454 N.E.2d 672, 676 (1983). Pursuant to 50 Ill. Admin. Code Section 7110.10(a), either party may request a vocational assessment when it appears a return to regular work will not occur or when the Petitioner is off work for at least 120 days. The first question then is has the Petitioner sustained a reduction in earning power?

His job as a truck driver/ loader was described in his initial FCE as being very heavy work. (RX 9) The second FCE, deemed valid by the examiner and adopted by Dr. Cobb, placed him essentially at a light duty level. (PX 10, Dep. X 2)

Dr. Cobb testified that he discussed the aspects of the Petitioner's job with him and did not feel he could perform all aspects of the job. He said, "I think he's a lot more likely to be able to drive

than he is to be able to drive and do some significant loading." (PX 10 at 24) He said that if the Petitioner is asked to lift too much, it could load the MCP joint and cause pain. (Id at 12)

Dr. Vender initially testified that the petitioner could not return to his normal activities, but then said it's very possible that he could return if he wore a splint. (RX 2 at 13) He never really gave a straight yes or no answer to the question. Later on he said "...So the main problem with his hand is that he doesn't have the same function with the index finger. So that would limit his lifting somewhat with that hand. It would be limited less if he was able to use a protective splint. So he would have some limitations without a splint. He would have less limitations with the splint. Brings it much closer to normal." (Id at 16) The Arbitrator has trouble reconciling that answer with Dr. Vender's later statements concerning the lack of need for an FCE in this case. He said that it didn't take much more than common sense to be able to figure out what the Petitioner can and cannot do. (Id at 19)

Moreover, petitioner offers the unrebutted opinion of psychologist, Dr. Hutchison, that petitioner suffers from a panic disorder with agoraphobia, such that having a fusion of the affected finger would not be indicated psychologically. Petitioner's treating physician, Dr. Cobb, testified that because the fusion of the finger is not psychologically indicated it is not medically indicated. That being the case, there is nothing further that can be offered to petitioner to reduce his pain and increase his function. As to function, Dr. Cobb persuasively opined that the Rock Valley Physical Therapy FCE, with valid findings, appropriately indicates petitioner's permanent work restrictions.

Petitioner testified that these restrictions made it impossible for him to return to his old position with respondent as a truck driver. Ms. Vogerich, on the other hand, testified that the Petitioner could return to truck driving, producing a labor market survey showing many available trucking jobs. However, she based her survey on the assumption that the Petitioner had no work restrictions, and the Arbitrator does not feel that is indicated by the evidence. The Petitioner had a heavy job. He has an injury which affects his ability to lift, and the testimony of both doctors allows the Arbitrator to reasonably infer that some restrictions are needed, along with a modified job.

Petitioner further testified that he conducted a substantial job search applying for the jobs listed on Ms. Vogerich's survey. He began his search on May 15, 2015, applying for 27 jobs in five weeks, without being hired. The search, admitted as Pet. Ex. 8, shows that in many of the jobs in trucking, the Petitioner was rejected because of his restrictions. He testified that he told the prospective employers about his restrictions from Dr. Cobb. Other jobs sought, such as a café clerk, sales associate and the like do not contain any information concerning the employer's response. Ms. Vogerich testified that the Petitioner could perform "no touch" driving jobs, which would not involve any lifting. The Petitioner testified that he did not think such jobs existed. In addition, petitioner has applied for vocational services with the Division of Rehabilitation Services seeking training in conducting a job search, interviewing and exploring fields for retraining.

At this point, the Arbitrator feels the case is ripe for a vocational assessment, and orders the Respondent to provide one. They should use Dr. Cobb's restrictions as a starting point, and if "no touch" jobs and others are available, they should be pursued.

With respect to maintenance benefits, the Arbitrator orders the Respondent to pay benefits from May 15, 2015, when he began to look for work, forward, so long as indicated by law. While the Petitioner's attorney did demand voc back in October 2013, he took no other steps to find work until May of this year. With no active treatment since Dr. Cobb's last visit at that time, and with no evidence of an attempt to find work after that FCE was obtained in early 2014, the Petitioner's request for back maintenance benefits is denied.

Respondent is also requesting the Arbitrator to make a fraud determination against the Petitioner pursuant to Section 25.5 of the Act. Essentially the Respondent claims that the numerous surveillance videos admitted into evidence prove that the Petitioner is capable of much more hand function than he reported to his various physicians and therapists and, as such, his claim for vocational rehabilitation and maintenance amounts to an intentional fraudulent claim for benefits under the Act. For reasons stated herein, the Arbitrator does not agree and denies the Respondent's request.

First of all, the medical records and testimony clearly provide objective proof of the Petitioner's injury. Following the accident, the Petitioner was seen on eight occasions at Genesis Occupational Health. He was found to have consistent examination findings of pain and swelling over the second MP joint of the right hand, laxity of the joint (see 1-20-2012) and an induration from the joint to the proximal phalanx of the index finger. The final diagnosis was a right second MCP joint dislocation and chronic arthritis. (PX 1) Dr. Cobb, a board certified orthopedic surgeon specializing in hand treatment, noted the same type of consistent findings over the course of the next three years. He observed swelling over the joint both before and after his surgery of June 11, 2012. Dr. Garst, an orthopedic surgeon who examined the Petitioner for a second opinion in May of 2013, noted chronic swelling and limited motion in and about the MP joint. He diagnosed chronic soft tissue inflammation and post traumatic arthritis. (PX 3) Dr. Vender, a board certified orthopedist who also specializes in hand treatment, saw the Petitioner on two occasions at the Respondent's request. On February 14, 2013, he noted visible swelling of the joint, palpable tenderness of the dorsal and palmar aspects, a substantial decrease in normal joint flexion and a mild decrease in extension and mild instability. (RX 2 at 11) A year later on March 17, 2014, he saw swelling of the joint and a mild amount of decreased flexion. (Id at 24) On both visits, he recommended the Petitioner undergo a joint fusion.

Nothing in the extensive surveillance videos refutes the objective findings noted above. For example, the Petitioner was shown on March 6, 2014 using a broom to clean snow off a roof and also try and dislodge ice from a gutter. While he was holding the broom with either hand, the video did not focus on his right hand to the extent needed to determine whether his MP joint was swollen or whether he was flexing or extending it in excess of the findings made by his physicians. None of the other scenes depicted the finger to the extent needed for the Arbitrator to draw any conclusions. The Arbitrator is mindful of Dr. Cobb and Dr. Vender's testimony concerning the Petitioner's functional limitations. Both doctors said that he could use his hand but that his use would be less than what he was able to do prior to his injury. Dr. Cobb opined

that the Petitioner could lift with the right hand but probably would put the object more across his palm than in his fingers with them being drawn into a fist. (PX 10 at 26) Dr. Vender said that the function of the index finger is reduced. It limits the Petitioner's ability to lift, but does not eliminate that ability. (RX 2 at 16, 17)

The videos simply do not demonstrate the Petitioner doing any sustained gripping and lifting with the hand while putting the right index finger into positions which the doctors said he could not do. Neither do they indicate that the Petitioner is able to exceed the limitations set forth in the FCE of February 13, 2014, which Dr. Cobb adopted as his recommended restrictions. They do not show the Petitioner carrying objects over ten pounds a distance of over thirty feet. They also do not show him lifting over twenty pounds with either or both hands to shoulder level.

As stated above, the evidence supports the Petitioner's claim for vocational help and maintenance. His request for those benefits is clearly not fraudulent.

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

Kevin McBee,
Petitioner,
vs.

NO: 13WC 20755

Bridgestone Americas,
Respondent,

16IWCC0390

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 4, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: JUN 14 2016
o060716
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
9(b)/8(a) ARBITRATOR DECISION

KEVIN McBEE
Employee/Petitioner

Case# 13WC020755

BRIDGESTONE
Employer/Respondent

16IWCC0390

On 6/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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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)/8(A)

Kevin McBee
Employee/Petitioner

v.

Bridgestone
Employer/Respondent

Case # 13 WC 20755

16IWCC0390

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Arbitrator Gregory Dollison**, Arbitrator of the Commission, in the city of **Peoria, Illinois** , on **March 17, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **September 15, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$54,357.68**; the average weekly wage was **$1,045.34**.

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

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

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

Pursuant to stipulation, Respondent is entitled to a credit under Section 8(j) of the Act for any medical paid by the group carrier.

ORDER

Having found that Petitioner's present right knee condition of ill-being is not causally related to the accident sustained, Petitioner's present 19(b)/8(a) Petitioner 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

6/3/15
Date

ICArbDec19(b)

JUN 4 - 2015

STATEMENT OF FACTS:

Petitioner testified that he was employed by Bridgestone as a press operator. He had been so employed for 28 years. Petitioner testified that on September 15, 2010, he had prepped a press. While doing so, a plate stuck to a tire. Petitioner stated that he used his right leg to break the tire free from the plate by stepping down on the plate. Petitioner provided that as a result of this action, felt a pop in his right knee. Petitioner stated that he would have to free plates from the tires frequently and would do so by stepping down on the plate.

Petitioner testified that he immediately reported the occurrence to his supervisor and prepared an accident report. Thereafter, he was referred to Dr. Lawrence Nord, the Company doctor. Dr. Nord's office records show he began treating Petitioner on September 21, 2010. Dr. Nord recorded a history that Petitioner presented with an "[i]nsidious onset of right knee discomfort while working at Bridgestone/Firestone. Patient states he felt a pop and sharp pain after pushing down on a piece of equipment at Bridgestone/Firestone." Dr. Nord diagnosed Petitioner with right knee internal derangement syndrome and ordered a MRI. (PX 1)

Petitioner underwent the prescribed MRI on September 22, 2010. The impression was as follows: tri-compartmental chondromalacia; large patellofemoral joint effusion with suprapatellar and medial synovial plica; deep quadriceps tendinopthy; deep infrapatellar bursitis; an acute subacute partial tear of the anterior cruciate ligament at the femoral insertion site; and attenuation in size of the body and posterior horn of the medial meniscus suggestive of a previous partial medial meniscectormy (It was noted that if there was no history of this, the findings would represent a complete tear). (PX 1)

Petitioner returned to Dr. Nord on September 28, 2010. The doctor diagnosed Petitioner with right knee tricompartmental chondromalacia, acute subacute partial tear of the anterior cruciate ligament, attenuation in size of the body and posterior horn of the medial meniscus suggestive of a previous partial medial meniscectormy. Dr. Nord injected the right knee with Xylocaine and Kenalog. He recommended weight loss, home exercises and physical therapy. Although Petitioner was released to return to work with no restrictions, Dr. Nord recommended that Petitioner avoid activities that aggravate his discomfort. (PX 1)

On October 26, 2010, Dr. Nord noted Petitioner reported low-grade discomfort in the right knee. Petitioner indicated some improvement following the injection. Dr. Nord indicated that if Petitioner's symptoms persisted, surgical intervention might be necessary. In a follow-up visit on November 23, 2010, Dr. Nord recorded that Petitioner's low-grade discomfort seemed to be aggravated by activity level and doing his work. Dr. Nord again injected the right knee with Xylocaine and Kenalog and again indicated that if symptoms persisted, Petitioner may require surgical intervention. (PX 1)

On December 23, 2010, Petitioner was again seen by Dr. Nord. In addition to the previously noted history, Dr. Nord recorded that Petitioner also had arthritis in the right knee. Dr. Nord noted that Petitioner's symptoms persisted despite conservative care. The doctor indicated Petitioner still had low-grade discomfort in the right knee, which seemed to be aggravated by activity level and doing his work. Dr. Nord administered a third injection and again indicated that surgical intervention may be necessary. Petitioner was continued on full duty work. (PX 1) By January 27, 2011, Dr. Nord noted that Petitioner's prognosis was improving and that there was no need for surgical intervention at that time. The doctor recommended a Knee orthotic and returned Petitioner to full duty work. On March 10, 2011, Dr. Nord recorded that Petitioner still had low-grade arthritis

discomfort in the knee. Petitioner requested an additional injection in the knee which the doctor administered utilizing Xylocaine and Kenalog. (PX 1)

Petitioner continued treating with Dr. Nord. On August 16, 2011, Dr. Nord administered an injection of Lidocaine and Aristospan in his right knee. On November 8, 2011, Dr. Nord noted Petitioner wanted to consider surgical intervention at that time. Dr. Nord wrote that Petitioner was going to contact Respondent to see if he could get off work for surgical intervention of his right knee. On February 14, 2012, Dr. Nord again administered an injection of Lidocaine and Aristocort and put on Meloxicam. At that time, Dr. Nord indicated Petitioner would eventually need knee replacement surgery. (PX 1)

Petitioner returned to Dr. Nord on May 15, 2012. Dr. Nord recorded that Petitioner's right knee pain was at 5/20 and intermittent in nature. Petitioner also provided that his knee was unstable and giving away. Diagnosis was right knee degenerative joint disease. Petitioner received an injection in his right knee and was to return in three months. Petitioner returned on September 11, 2012 wherein he had another right knee steroid injection and had a diagnosis of right knee moderate to severe degenerative joint disease. The doctor also reported that Petitioner would eventually need a total knee replacement. (PX 1)

On January 31, 2013, Dr. Nord recorded in his notes that Petitioner presented for a consultation at the request of Sheryl at Bridgestone/Firestone. Dr. Nord noted "the symptoms have been present for two years. The symptoms are the result of or related to a(n) direct trauma...The symptoms are severe. The pain is described as constant catching, grinding, locking and popping...The symptoms is/are exacerbated by climbing stairs/ladders and weight bearing. This is a continued workers' compensation claim with BSFS (Bridgestone/Firestone). The accident occurred in 2010. It was reported to a nurse immediately." Record submitted show "Services Performed: 99214 Est. Pt.: comp. mod." Dr. Nord diagnosis was right knee moderate to severe DJD. His recommendation was a right knee total knee replacement to be set up in the near future. (PX 1)

On January 31, 2013, Dr. Nord also drafted correspondence to Sheryl Donahue at Bridgestone/Firestone. Dr. Nord wrote, "Kevin McBee,...has been under my care and treatment for arthritis discomfort in his right knee. The patient previously had undergone right knee arthroscopic debridement by Dr. Novotny in 2005. This patient has underlying osteoarthritis, which is not work related. However, the extent of his knee arthritis has progressed to the point now when he probably needs to undergo right total knee replacement. There is no causal connection of the patient's bilateral knee arthritis regarding his work at Bridgestone/Firestone." (RX 3)

Petitioner testified that after he was advised he needed a total knee replacement, the claim was denied as being work-related. Subsequent thereto he sought treatment with Dr. Mark Hansen. Petitioner first presented to Dr. Hanson on September 4, 2013. A "Patient Information Record" prepared by Petitioner show he indicated that his job as a "press operator" contributed to his pain. On an "Insurance Information" form also completed by Petitioner, indicate that his injury was not work related. Dr. Hansen records show Petitioner's chief complaint of "knee problem." Records show Dr. Hanson noted Petitioner had complained of pain at the anterior and medial portion of the right knee. Dr. Hanson noted a long history of increasing pain with time. The timing was chronic and the context could not be identified. Also noted was that the matter was work related. Dr. Hanson reviewed x-rays taken which he indicated revealed severe osteoarthritis right knee with varus pattern and bone on bone medially. After performing an examination, Dr. Hanson diagnosed severe right knee osteoarthritis and recommended a total knee replacement which was ordered on September 19, 2013. Dr. Hanson's recommendation was approved by Petitioner's group health carrier, Blue Cross BlueShield of Tennessee. The surgery was scheduled for October 28, 2013. However, during preoperative screening, it was determined Petitioner was pre-diabetic. Also, Petitioner reported developing seizures. As a result, the scheduled total knee replacement was cancelled. (PX 2)

Petitioner returned to Dr. Hanson on February 11, 2014. Dr. Hanson continued to assess severe right knee osteoarthritis. Dr. Hanson commented that 33 years of working has accelerated and aggravated this arthritis and his need for total knee replacement. Dr. Hansen recommendation for a total knee replacement continued. (PX 2)

Petitioner testified that currently he has pain radiating down his right leg. He experiences swelling in the right knee and extended sitting causes soreness and stiffness. He provided that standing helps with same.

Petitioner testified that his employment with Respondent ended on May 30, 2013 when he developed a seizure condition. Petitioner testified that since May of 2013 he has been working at a Sam's Club gas station. He testified that he works 30 hours a week and stands for that period of time. Petitioner also testified that he did not undergo the surgery while working for Respondent because his wife was laid-off and he needed to continue working to make ends meet. Petitioner wished to proceed with the total knee replacement.

Petitioner's testimony and the records submitted show Petitioner underwent an arthroscopy years ago performed by Dr. Joseph A. Novotny. Petitioner testified that he returned to work post-surgery in 2004-2005. Petitioner stated that from the time he returned through the date of occurrence, he was "doing ok." He indicated he had no problems performing his duties indicating he was able to "run a room full of different presses." Petitioner testified that he did not miss any time from work and performed his duties through September of 2010. Petitioner could not recall if he treated for the right knee after November of 2005. He could not recall if he had continued symptoms after November of 2005 through September of 2010.

Records submitted show Dr. Novotny performed a diagnostic right knee arhthroscopy followed by partial medial menisectomy; chondroplasty of medial tibial plateau, lateral femoral condyle and tochlear groove. The operative report for the right leg surgery performed on December 17, 2001 show a defect was noted in the trochlear groove with unstable cartilage which was debrided. A meniscus tear was identified and repaired. The report also indicated Grade IV chondromalacia in the medial tibial plateau. That was debrided. A large full thickness defect in the lateral femoral condyle was also debrided. The post-operative diagnosis was Grade IV chondromalacia defect of the lateral femoral condyle and the trochlear groove and medial tibial plateau. A degenerative tear of the posterior horn of the medial meniscus was also noted. (RX 9A)

Post-operatively, Petitioner continued to treat with Dr. Novotny. Records show Petitioner was seen on July 25, 2002. Dr. Novotny noted Petitioner had an arthroscopy performed seven months earlier and was found to have significant chondromalacia, and Grade IV defects both medially and laterally. The doctor noted Petitioner had recurring right knee pain. He told the doctor that it hurt worse with stair climbing and bicycle riding. He had pain mainly in the medial joint line. At the end of the day he had pain and discomfort with prolonged activities. He advised Dr. Novotny that he was taking glucosamine and wearing knee sleeve which provided some relief of his symptoms. The diagnosis was symptomatic knee arthritis with occasional mechanical symptoms. The doctor indicated that if his symptoms worsened he may require interarticular steroid injection. (RX 13)

Dr. Novotny's records reflect that Petitioner was seen on October 21, 2002. Dr. Novotny diagnosed diffuse degenerative changes with chondral defects. At that time, Petitioner complained of recurrent pain in the right knee. He had done well for several months. He was concerned about carrying heavy loads and carrying his son. He had sudden sharp pain with give-way sensation in the right knee. Crepitation was noted on range of motion as well as medial joint line pain. X-rays revealed significant medial joint space narrowing with subchondral tibial sclerosis and peripheral osteophytes in the patellofemoral joint. The diagnosis was symptomatic degenerative joint disease of the right knee. Dr. Novotny noted that apparently, Petitioner had

received intraarticular steroid injections from his primary care physician. Petitioner was given an additional steroid injection that day by Dr. Novotny. (RX 13)

On November 19, 2002, Dr. Novotny authored a causal relationship opinion regarding the genesis of Petitioner's right knee condition. Dr. Novotny wrote, "He sustained this injury at work. Kevin's job required him to jump several times a day sustaining an axial load injury to his right knee. This repetitive microtrauma ultimately led to the development of a symptomatic meniscus tear as well as symptomatic degenerative changes related to full thickness cartilage defects in the knee. (RX 10)

On February 6, 2003, Dr. Novotny recorded that Petitioner complained of recurring right knee pain. He continued to have episodic discomfort and he wanted to know if there was anything further which could be done. Dr. Novotny advised about Supartz injections and Petitioner decided he wanted the same. (RX 13)

On April 8, 2004, Dr. Novotny administered a Supartz injection. X-rays were also obtained that day which revealed a fair amount of patellofemoral degenerative changes with superior and inferior osteophyte formations. Dr. Novotny recorded that he thought it was most likely medial knee arthritis. He recommended Supartz injections to see if long term significant relief was attainable. He indicated that if same failed, then "Otherwise treatment may consist of a unicompartmental possible total knee arthroplasty." (RX 13) In the present claim, Petitioner testified that he could not recall whether or not Dr. Novotny had advised him in 2004 that he may need a knee replacement.

Petitioner continued to treat with Dr. Novotny through May of 2004. Dr. Novotny's records reflect Petitioner received three Supartz injections for a total of five Supartz injections. Prior to his last injection on May 26, 2004, Petitioner reported symptomatic improvement. (RX 13)

Petitioner filed and pursued a claim against Respondent for the right knee injury of 2001. The Commission found Petitioner did not sustain the claimed right knee injury at work, rather, he sustained the right knee injury at an amusement park (07 IWCC 484). (RX 6)

Petitioner was questioned regarding testimony he provided in that case which was held on November 11, 2005. He testified that he could not recall any of his testimony. A review of the testimony show that Petitioner testified, at that time, that he noticed "a lot of popping, pain on the side of the [right] knee, grinding." He stated that "If I'm sitting down for a long period of time, it falls asleep." Petitioner also provided that his right knee pain was worse that his left knee. (In addition to the right knee filing, Petitioner filed a claim for his left knee which was found compensable) (RX 4, pgs. 30-31)

Dr. Nord testified via deposition in this matter on December 8, 2014. Dr. Nord testified that when he saw Petitioner on September 21, 2010, Petitioner complained of insidious onset of right knee discomfort. The doctor stated Petitioner was not sure exactly what bought the pain on, but he felt a pop and sharp pain after pushing down on a piece of equipment at Bridgestone. Dr. Nord testified that Petitioner did not mention anything about direct trauma to the right knee. Petitioner also provided a history that he had previously undergone right knee surgery performed by Dr. Novotny in 2006. Dr. Nord took x-rays of the right knee which he felt revealed medial joint compartment narrowing caused by osteoarthritis. Dr. Nord stated that arthritis was not related to the September 15, 2010 claimed injury. The doctor indicated same "would have preceded his complaint of discomfort following his incident at Bridgestone." Dr. Nord testified that he diagnosed Petitioner with internal derangement with underlying arthritis. The doctor also provided that after performing an examination, he did not feel there was any clinical evidence of an acute ACL tear. Instead he felt Petitioner's examination and symptoms demonstrated a chronic tear. (RX 12, pgs 8-11) (RX 12, pg. 13)

Dr. Nord ordered a MRI of the right knee. The doctor provided that the findings showed severe chondromalacia of the medial compartment which he felt was consistent with moderate to severe degenerative changes, indicating arthritis in the knee. The MRI further demonstrated an acute to subacute partial tear in the medial meniscus consistent with a previous medial meniscectomy. Dr. Nord testified that the chondromalacia noted could not have resulted from the claimed injury because the extent of the arthritis could not have developed in one week. He opined that the partial tear of the ACL noted on the MRI was not causally connected to the claimed injury due to the examination and the symptoms. Dr. Nord testified that none of the findings on the MRI were causally connected to the claimed injury as they were all chronic and pre-dated the injury. Dr. Nord thought the injury that Petitioner complained of may have aggravated some underlying arthritis in the knee and caused some swelling and discomfort in the knee but it didn't seem to be causing any of the findings on the MRI. (RX 12, pgs. 14-16)

Dr. Nord testified regarding Petitioner's return visits. By October 26, 2010, Dr. Nord felt Petitioner's discomfort was caused by arthritis. Dr. Nord testified Petitioner had a temporary aggravation of the arthritis in his knee. The doctor provided Petitioner at that time did not want to treat the underlying cause of his knee pain, which was arthritis. Treatment for same would require surgery. However, Petitioner wanted intermittent medical management. As such, steroid injections were administered. (RX 12 pgs. 19-20)

By January 27, 2011, Dr. Nord had administered three (3) injections. Dr. Nord testified that by that time any temporary aggravation had resolved. At this point, Dr. Nord reported he was treating Petitioner solely for his chronic knee arthritis. (RX 15, pgs 22-25)

Dr. Nord testified that when he saw Petitioner on March 10, 2011, Petitioner still complained of low grade arthritis discomfort and requested a steroid injection which the doctor administered. Dr. Nord testified that the temporary aggravation of Petitioner's knee pain from the injury subsided within the first six to twelve weeks after the incident and from that point forward, Petitioner was being treated for chronic arthritis. (RX 15, pg. 26)

Dr. Nord testified that he continued to treat Petitioner chronic arthritis. Dr. Nord testified that on November 8, 2011, Petitioner complained of occasional give-way in the knee. Dr. Nord stated same suggested the nature of the arthritis was becoming worse. Dr. Nord testified Petitioner's prognosis was poor and he would need a total knee replacement for relief. He indicated that the type of arthritis Petitioner has is one that continues to worsen due to the bone on bone rubbing. (RX 12, pgs. 27-30)

On February 14, 2012, the diagnosis was moderate to severe arthritis. The doctor provided that he underlying severe arthritis continued to worsen and ultimately would require a total knee replacement. (Resp. Ex. No. 12, p. 31-36). On September 11, 2012, Petitioner had moderate to severe degenerative joint disease. Dr. Nord provided that his condition was chronic and had become worse since he first saw Petitioner. (RX 12, pgs. 31-36)

Dr. Nord testified that he saw Petitioner on January 31, 2013. The doctor provided that the nurse at Bridgestone requested Dr. Nord's opinion whether the treatment he continued to provide to Petitioner was causally related to the work injury. (At this point, Petitioner's attorney raised a *Petrillo* objection which the Arbitrator will address below.) Dr. Nord testified that he prepared a letter (See RX 3) in response to that request. Dr. Nord indicated that the ongoing treatment was for underlying osteoarthritis and was not work-related. He felt Petitioner would need a right total knee replacement. Dr. Nord indicated that there was no causal connection between the bilateral knee arthritis and the Petitioner's job. (RX 12, pg. 37-41)

Dr. Nord was shown the entry in his records for January 31, 2013. He testified that on that date he did not perform the initial evaluation. He testified that the history was taken by a trainer. The history indicated that Petitioner's symptoms were related to a direct trauma. Dr. Nord testified that he was unaware of any direct trauma. The entry indicated that this was a continuing workers' compensation claim. Dr. Nord testified that that was not his opinion and he did not write that. Dr. Nord testified that he thought the workers' compensation aspects of the claim ended approximately three months after Petitioner was first seen. He stated that "from that point forward, it was just strictly for chronic arthritis in the knee. (RX 12, pgs. 41-43) Petitioner's diagnosis was moderate to severe degenerative joint disease which Dr. Nord testified was not causally related to the claimed injury. (RX 12, pg. 45) Dr. Nord testified that he advised Petitioner that he could consider a right total knee replacement. The doctor however indicated the surgery would not be causally connected to the claimed work injury. (RX 12, pg. 46)

On cross-examination, Dr. Nord testified that he signed off on the office note of January 31, 2013 and there was no indication that any other individual co-wrote the report. Dr. Nord agreed the office note says direct trauma. The doctor clarified the remark stating, "What I was kind of referring to as insidious onset, like it was a temporary aggravation. I think he probably could have – with the arthritis he had in the knee, he probably could have stepped on anything and if he pushed hard enough, could have had some pain or felt some pop in the knee because the knee was arthritic at that time…it's just another incident in his life that he probably aggravated some arthritis in his knee and that just happened to be out at Bridgestone on that date." (RX 12, pgs. 49-51) Dr. Nord stated that based on Petitioner's history of knee problems since 2005, he felt the work resulted in a temporary aggravation and not an aggravation that continued throughout. He felt the temporary aggravation ended in December 2010. (RX 12, pgs. 52-53)

Dr. Nord testified that when he initially offered surgery, he did not feel same was work related. He felt it was due to the chronic arthritis in the knee. (RX 12, pg. 61) Dr. Nord testified that he stated he did not know what damage was caused by the September 15, 2010 accident but when looking at the chronic changes on the MRI which predate the injury, whatever happened on that day could have aggravated any one of these conditions in here and caused temporary pain from it. (RX 12, pg. 65)

Dr. Nord testified that there are several companies that refer patients to him. Dr. Nord provided that the companies want him to send an employment status report right after they leave the office so they know what he has diagnosed, what restrictions he has placed on the employee and what treatment was recommended. Dr. Nord stated Respondent is one of those companies he gets referrals from. The doctor provided that he does not have a contractural agreement with any of them, nor does he receive any money from the directly. Respondent has been referring employees since 1980. (RX 12 pgs. 75-76)

Dr. Nord was questioned regarding the conflicts between his letter of January 31, 2013 and his office note. The doctor testified, "I think it seems consistent that what the trainer put down,…said the patient presented with knee pain. It says the patient presents today for consultation through request of Cherly from Bridgestone/Firestone. The symptoms have been present for two years, which is consistent with what the patient said. The symptoms are a result of a related – to direct trauma, which the patient apparently told the trainer he felt it was from this incident where he stepped down and felt a pop and pain in the knee. Said patient is no better, which is fairly consistent, because arthritis is probably not going to get better…And it says this is a Workers' Comp claim at Bridgestone/Firestone. I don't know if this case has actually been covered under workers' comp or the patient's Blue Cross insurance. I personally don't know. If that's what he told the trainer, then that's what he told the trainer and that's what he put down. Put the accident occurred in 2010. It was reported to the nurse immediately. And so I don't have a problem with what he put down there. My only comment is that because of the severity of the arthritis in the knee, I felt that whatever he did when he

aggravated the knee was just a temporary aggravation lasting for about three months after that, and that's the only thing that I would add to it." The doctor further stated that he did state in the January 31, 2013 letter that Petitioner had progressive osteoarthritis which was not work-related. (RX 12, pgs. 78-79) Dr. Nord testified that while he was treating Petitioner he did not know whether the treatment was being paid through workers' compensation or through Blue Cross. (RX 12, pg. 80) Dr. Nord stated that Petitioner certainly did something at work that aggravated his knee arthritis and the nurse felt he needed to come in and see him to get evaluated. (RX 12, pg. 85)

Dr. Nord testified that "...if look at the big picture on this progression of this patient's arthritis in his knee, ...I think anything he did could have caused a catch or a sharp pain in the knee because of the amount of cartilage that had been worn off the knee. Because if it was very severe he would have had a lot of swelling in the knee, and it was only a one (1) plus effusion, and it never changed. And if it was an acute injury that really caused much of a problem, you would have seen like a really swollen knee, and then the swelling would have gradually gone out, but the swelling pretty much stayed consistent throughout. (RX 12, pgs. 87-88)

On redirect examination, Dr. Nord reviewed a physical therapy report of October 20, 2010. Therein Petitioner reported he did not have any pain. Dr. Nord testified that this suggested that Petitioner's symptoms from whatever occurred on September 15, 2010 were temporary and not permanent. He never imposed any restrictions on Petitioner's ability to work. (RX 12, pg. 94, 96-97)

The deposition of Dr. Hansen was taken May 14, 2014. Dr. Hansen testified that he first saw Petitioner on September 4, 2013. The doctor noted that Petitioner had previously been seen by Dr. Novotny. Dr. Hansen stated Petitioner complained of right knee pain mostly on the inner portion and in the front of the knee. Dr. Hansen stated Petitioner conveyed that he felt work made it worse. Dr. Hansen noted Petitioner had undergone surgery ten years prior which he believed was an arthroscopy. Dr. Hansen testified that Petitioner had severe arthritis and would have expected him to have pain. The doctor provided that x-rays taken showed Petitioner had bone-on-bone arthritis medially. He explained that same indicated Petitioner was becoming bow-legged because he was wearing out the medial joint and also at the patella. Dr. Hansen stated he diagnosed severe right knee osteoarthritis and recommended a total knee replacement. (PX 5, pgs. 6-8)

Dr. Hansen testified that he re-examined Petitioner on February 11, 2014 and the findings were similar. The doctor noted Petitioner had the total knee scheduled for October but his diabetes delayed it and wanted to talk further about surgery. Dr. Hanson continued to recommend a replacement as long as Petitioner was medically cleared with his diabetes and seizure under control. (PX 5 pgs. 10-11)

Over objection from Respondent (addressed below), Dr. Hansen was posed a hypothetical question which included a history of Petitioner pushing down on a piece of equipment, feeling a pop with pain in his right knee on September 15, 2010. Included in the hypothetical was the course of treatment with Dr. Nord which included the MRI of September 22, 2010 revealing a tri-compartment chondromalacia, large patellofemoral joint effusion with suprapatellar and medial synovial plica; deep quadriceps tendinopthy; deep infrapatellar bursitis; an acute subacute partial tear of the anterior cruciate ligament at the femoral insertion site; and attenuation in size of the body and posterior horn of the medial meniscus suggestive of a previous partial medial meniscectormy. Dr. Hansen testified that he felt the described injury was the type of injury which could cause acceleration of the arthritis. Dr. Hansen testified that the activity could have accelerated the arthritis but certainly did not cause it. (PX 5, pgs. 11-16) Dr. Hansen also testified that 33 years of working accelerated and aggravated Petitioner's arthritis and the need for a total knee replacement. (PX 5, pg. 19)

On cross-examination, Dr. Hansen testified that he was not aware of Dr. Nord's treatment, findings or recommendations. prior to the date of his deposition. The doctor indicated Petitioner never mentioned the fact that he treated with Dr. Nord. (PX 5, pgs. 20-21)

Dr. Hansen testified that Grade IV chondromalacia is bone-on-bone which meant the medial femoral condyle and tibial plateau condyle were in contact. Dr. Hansen testified that he never saw the actual film of the September 22, 2010 MRI. Dr. Hansen indicated the recommendation for the total knee replacement was for the pre-existing osteoarthritis. He indicated that the need for the total knee replacement had nothing to do with an ACL tear. He provided that he didn't know Petitioner had an ACL tear when he recommended the surgery. The doctor stated, "...if his 2010 MRI is right that he had an ACL tear, well, then, he would still have an ACL tear, but it wouldn't be relevant. The reason he needs a knee replacement is because he's bone on bone." Dr. Hansen admitted he could not state how long Petitioner had bone-on-bone arthritis. (PX 5, pgs. 22-24)

Dr. Hansen reiterated that he didn't know when Petitioner's arthritis started. He provided that Dr. Novotny found some arthritis when he scoped Petitioner in 2001. He stated that the scope was for a meniscus tear and not for arthritis. Dr. Hansen agreed that Dr. Novotny continued to treat Petitioner after 2001 for arthritis and that the osteoarthritis pre-dated the September 2010 incident. (PX 5, pgs. 27-29)

Dr. Hansen testified that before his deposition started, he did not know anything about a claimed September 15, 2010 injury. The doctor provided that he did not know anything about the condition of the knee the day before the injury or if there were any changes in Petitioner's condition after the claimed September 15, 2010 injury. (PX 5, pgs. 29-31)

During the deposition, Dr. Hansen was shown a copy of Dr. Novotny's records dated November 19, 2002 wherein Dr. Novotny indicated that at that point there were multiple areas of full thickness cartilage defects which may ultimately lead to a total knee replacement. Dr. Hansen provided that same would indicate there was evidence of full thickness cartilage defect at that time with bone-on-bone. Dr. Hansen stated that a total knee replacement becomes appropriate treatment depending on the size of the defect. (PX 5, pgs. 31-32) Dr. Hansen provided that persons with severe osteoarthritis will not improve on its own. The course is for it to become worse. He indicated that given the degree of osteoarthritis Petitioner had in 2001 it was not unexpected that twelve years later he would need a total knee replacement from the underlying condition. He also provided that the need could occur without trauma, it is the normal course of degenerative joint disease. (PX 5, pg. 33)

Dr. Hansen reviewed additional records from Dr. Novotny. The doctor admitted that based on the records he reviewed, the arthritis Petitioner had in February of 2003 did not improve. He still had symptomatic arthritis in April of 2004. He admitted that a total knee replacement was one of the considerations at that time. He testified that another option that was discussed was uni-compartment surgery and either that or a total knee replacement would be appropriate treatment for symptomatic arthritis as noted in April of 2004. (PX 5, pgs. 34-36) Dr. Hansen admitted that on July 25, 2002, Petitioner was diagnosed with Grade IV chondromalacia. Dr. Hansen provided that symptoms of severe osteoarthritis would include pain, swelling, stiffness, loss of motion and decreased activity. Dr. Hansen admitted that Petitioner had all these symptoms from 2001 through 2004 from the arthritis. (PX 5, pg. 38) Dr. Hansen concurred that Dr. Novotny in 2004 indicated that Petitioner may ultimately need the same total knee replacement that he suggested twelve years later. Dr. Hansen indicated that the need for the surgery in 2013 may be the normal deterioration of the condition Petitioner had twelve years earlier and that the need for the surgery he was suggesting in 2013 could be related to the condition noted in 2002. (PX 5, pgs. 38-40)

At Respondent's request, Petitioner was evaluated by Dr. James Cohen for a Section 12 examination on August 26, 2014. Dr. Cohen also testified via deposition in this matter.

Dr. Cohen testified that in addition to obtaining a history from Petitioner, he also performed an examination and reviewed numerous medical records including diagnostic studies and surgical records. Dr. Cohen reviewed an x-ray report of the right leg of July 24, 2001 which revealed slight joint space narrowing in the medial compartment; a MRI of the right knee of November 29, 2001 revealing a tear of the medial meniscus with degenerative changes in the posterior horn of the medial meniscus; an operative report of December 17, 2001 indicating Petitioner had Grade IV chondromalacia of the lateral femoral condyle, trochlear groove, medial tibial plateau and degenerative unstable tear of the posterior horn of the medial meniscus (Grade IV chondromalacia was described by Dr. Cohen as "down to the bone, bad arthritis."). Dr. Cohen reviewed the operative photos of Petitioner's right knee from the December 17, 2001 arthroscopy. Dr. Cohen testified the photo showed a full thickness large defect in the lateral femoral condyle with a large area of complete chondral loss and degenerative changes. Bare bone on the medial aspect of the medial tibial plateau with evidence of a medial meniscus tear was noted. Dr. Cohen testified that the photos of the surgery of December 17, 2001 revealed severe arthritis in the medial and lateral compartments of the knee. (RX 5, pgs. 14-18)

Dr. Cohen testified that he reviewed a note from Dr. Novotny of January 17, 2002. Therein, Dr. Novotny, who released Petitioner for work, indicated that he may need further treatment as he had significant cartilage damage as noted on the arthroscopy. Dr. Cohen noted Petitioner was seen by Dr. Novotny on July 25, 2002 wherein he was assessed with symptomatic knee arthritis with occasional mechanical pain. (RX 5, pgs. 22-23)

Dr. Cohen testified that on November 19, 2002, Dr. Novotny felt Petitioner's prognosis was guarded in that he had multiple areas of full thickness cartilage defect in the knee which may ultimately require a total knee replacement. Dr. Cohen testified that this suggested that as early as 2002 Petitioner had damage to the cartilage with advanced arthritic changes. Dr. Cohen felt that the findings noted in 2002 would have justified recommendation for a total knee replacement at that time. Dr. Cohen reviewed Dr. Novotny's records from 2002 through April of 2004. Dr. Cohen noted that in April of 2004, Petitioner had received a series of injections and that the X-rays taken in 2004 revealed a fair amount of patellofemoral degenerative changes with superior and inferior osteophyte formations. Dr. Cohen explained that there were bone spurs developing around the front of the knee joint. (RX 5, pgs. 24-28)

Dr. Cohen testified that he reviewed Dr. Nord's records of September 21, 2010 wherein Dr. Nord noted Petitioner had an insidious onset of right knee discomfort and felt a pop with sharp pain after pushing down on a piece of equipment. Dr. Cohen provided that he reviewed the film taken in September of 2010 and the MRI report. Dr. Cohen opined same showed degenerative changes. He did not feel there was evidence of a complete ACL tear. (RX 5, pg. 32) Dr. Cohen reviewed Dr. Hansen's records noting the doctor's severe right knee osteoarthritis diagnosis on February 11, 2014. (Resp. Ex. No. 5, p. 36) Dr. Cohen testified that he also reviewed transcripts of the evidence depositions of Dr. Hansen, and Dr. Novotny. (RX 5, pg. 37)

Dr. Cohen testified that during his examination, the ACL in the right knee seemed to be functioning fine. Dr. Cohen testified that he reviewed the films of September 22, 2010. The findings were consistent with degenerative arthritis of the knee and were unrelated to an injury occurring on September 15, 2010. (RX 5, pgs. 39-44) Dr. Cohen also reviewed x-rays taken on September 4, 2013. The doctor opined those findings were unrelated to the September 2010 incident, indicating they were longstanding, chronic degenerative changes. Dr. Cohen also opined that neither the MRI nor the x-ray showed any evidence of an aggravation from the September 15, 2010 claimed injury. (RX 5, pg 46)

Dr. Cohen testified that he reviewed the surgical photos from 2001. He provided that the photos showed severe arthritic changes and cartilage loss. Dr. Cohen concluded Petitioner had severe arthritic changes in the medial and lateral compartments in December of 2001. Dr. Cohen testified that the changes in the arthritis noted in 2010 could not be the result of an injury occurring on September 15, 2010 because progressive arthritis was shown and not traumatic injury. Dr. Cohen testified that the records he reviewed (the September 2010 MRI, the 2013 X-rays and the office notes after 2010) were inconsistent with the conclusion that Petitioner sustained an acute trauma on September 15, 2010. The doctor stated that all the changes noted were degenerative. (RX 5, pgs. 48-52)

Dr. Cohen testified that he agreed with Dr. Novotny's opinion of 2005 that Petitioner at some point during his life would most likely need a total knee replacement due to the severe arthritis. Dr. Cohen testified that Petitioner had severe symptoms and pain in the right knee for at least three years after the 2001 arthroscopy which was caused by severe arthritis in the knee. That type of arthritis would eventually require a total knee replacement. Dr. Cohen was of the opinion that the incident of September 15, 2010 did not accelerate or aggravate Petitioner's underlying condition. The doctor felt Petitioner's symptoms were a manifestation of a severe arthritic condition which started and was present since at least 2001. Dr. Cohen testified that as Petitioner's arthritis deteriorated over time, pain could occur without any trauma. (RX 5, pgs. 52-56) Dr. Cohen also stated that the total knee replacement that Dr. Hansen recommended is the same type of surgery Dr. Novotny discussed back in April 2004. (RX 5, pg. 57)

On cross-examination Dr. Cohen was asked whether frequent stepping on Petitioner's foot at work was the type of activity that would accelerate advanced arthritis. Dr. Cohen was of the opinion that said type of the activity would not accelerate advanced arthritis. He indicated that "people can have a temporary increase in symptoms from activity with arthritis, but it doesn't change the natural history." (RX 5, pgs. 87-88) Dr. Cohen provided that Petitioner's symptoms manifested themselves on September 15, 2010, as Petitioner was complaining of pain. (RX 5, pg. 89) Dr. Cohen however stated that the symptoms Petitioner had for which he was seen by Dr. Nord and Dr. Hansen were unrelated to the September 15, 2010 injury. Dr. Cohen stated, "...he was complaining of symptoms. But with his severe arthritic changes in his knee and the fact that he had documented ongoing symptoms for a period of three years in the records I reviewed, that I believe that he was having ongoing symptoms in his knee. I can't imagine that he was symptom-free." (RX 5, pgs. 90-91) Dr. Cohen testified that arthritis can be aggravated by a work incident if there is a significant chondral injury. (RX 5, pg. 95)

Dr. Cohen testified that the fact Petitioner was able to work for three years after the claimed injury of 2010, demonstrated that he could work with symptomatic knee arthritis. Dr. Cohen testified that the operative findings were significant enough to justify a total knee replacement in 2004. Dr. Cohen testified that Petitioner's arthritic findings from 2001 through 2004 reflected that he had Grade IV arthritis. Those are the same findings which led Dr. Hansen to recommend a total knee replacement in 2013. (RX 5, pg. 102) Dr. Cohen testified that there wasn't anything in Dr. Nord's records suggesting there was an acceleration of the underlying arthritic condition. Dr. Cohen agreed with Dr. Nord's January 31, 2013 report that Petitioner had underlying osteoarthritis which was not work-related. (Resp. Ex. No. 5, p. 104) Dr. Cohen clarified that Petitioner's job which involved stepping on a tire would not accelerate his underlying end-stage arthritis. (RX 5, pgs. 106-107) Dr. Cohen testified that had Petitioner undergone a total knee replacement prior to September of 2010, he would have agreed with that treatment. (RX 5, pg. 110)

Dr. Cohen testified that the fact Petitioner had pain at work did not mean that there was a change in the underlying condition. Dr. Cohen testified that arthritis caused Petitioner's pain and the pain was not related or

caused by the stepping activities at work. He would have pain while stepping, but the pain was from the arthritis and not the activity. (RX 5, pgs 114-118)

Regarding (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following.

Petitioner claimed that he sustained a work injury on September 15, 2010. Respondent has disputed that he sustained a compensable injury at work. Petitioner's unrebutted testimony demonstrates that on September 15, 2010, he had prepped a press. While doing so, a plate stuck to a tire. Petitioner used his right leg to break the tire free from the plate by stepping down on the plate. As a result of this action, he felt a pop in his right knee. Petitioner immediately reported the occurrence to his supervisor and prepared an accident report. Thereafter, he was referred to Dr. Lawrence Nord, the Company doctor. Dr. Nord's office records show he began treating Petitioner on September 21, 2010. Dr. Nord recorded a history that Petitioner presented with an "[i]nsidious onset of right knee discomfort while working at Bridgestone/Firestone. Patient states he felt a pop and sharp pain after pushing down on a piece of equipment at Bridgestone/Firestone." Dr. Nord diagnosed Petitioner with right knee internal derangement syndrome.

Based on the above, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment on September 15, 2010.

Regarding (F) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following.

Evidence submitted shows that Petitioner underwent surgery to the right leg on December 17, 2001. At that time, Petitioner had a full thickness defect in the lateral femoral condyle with bone-on-bone in the medial aspect of the medial tibial plateau. Dr. Cohen, Respondent's expert, felt Petitioner's complaints when seen in August 2014 were not related to the claimed 2012 injury. He based his opinion regarding the findings in 2001 on the actual photos taken during surgery on December 17, 2001.

Petitioner testified that he had a relatively uneventful recovery subsequent to the surgery in 2001. However, the records of Dr. Novotny show a clear course of treatment to the right knee, through at least May of 2004 without significant improvement. Petitioner underwent a series of five supartz injections with no evidence that his condition improved. As early as November of 2002, it was noted that Petitioner would ultimately need a knee replacement. That recommendation was made again in April of 2004.

As a result of the September 15, 2010 incident, Petitioner began treating with Dr. Nord who recorded a history of insidious onset of right knee pain. Dr. Nord testified that this may have been an aggravation of pain but it was only temporary. Dr. Nord testified that as of January of 2011 the temporary aggravation had clearly resolved. Dr. Nord testified that as of that date, Petitioner's symptoms were strictly the result of the pre-existing arthritis. Dr. Nord also reviewed a physical therapy report of October 2010 and noted that at that time, Petitioner's complaints and symptoms had resolved and whatever temporary aggravation that had occurred in September of 2010, had resolved. Dr. Nord further testified that there was no permanent aggravation as Petitioner's swelling in the knee did not change over the course of time he treated Petitioner. Dr. Nord testified that if in fact there had been a traumatic event, there would have been an increase in swelling which would have diminished over a period of time. Dr. Nord saw Petitioner from 2010 until January of 2013. He testified that there was no change in swelling, which suggested to him that Petitioner's condition was chronic. Dr. Nord specifically testified that the need for the proposed knee replacement was severe, pre-existing osteoarthritis. Dr.

Nord testified that in his opinion, the activity of September 15, 2010 did not in any way cause, aggravate or accelerate the need for the knee replacement.

Dr. Cohen, Respondent's Section12 examiner, who has extensive experience with knee replacements, testified that he reviewed MRIs before and after September 15, 2010. He reviewed the films from the surgery in 2001, reviewed the MRI after September 15, 2010 and compared the same. He testified that the pre-September 2010 MRIs, films and operative reports, demonstrated a severe, degenerative, arthritic right knee condition. Dr. Cohen testified that based on the records of Dr. Novotny and the materials he reviewed, Petitioner would have been a viable candidate for a knee replacement as early as 2002 and was certainly a candidate in 2004. Dr. Cohen testified that the condition Petitioner had when he examined him and the need for the knee replacement after September 15, 2010 was strictly the result of the pre-existing degenerative arthritis which had been present since at least 2001. When asked, Dr. Cohen testified that the activity of stepping on the tire, would neither cause, aggravate or accelerate Petitioner's underlying arthritic condition.

Dr. Hansen offered a causal relationship via deposition in this matter. Respondent objected to Dr. Hansen's opinions regarding causal connection. The Arbitrator finds the testimony of Dr. Hansen is allowed and is not in violation of the decision in *Ghere*. Respondent argues that the Arbitrator should exclude Dr. Hansen's causation testimony based on *Ghere v. Industrial Comm'n,* 278 Ill.App.3d 840, 215 Ill.Dec. 532, 663 N.E.2d 1046 (1996), because no report was tendered to employer in advance of the testimony notifying employer that Dr. Hansen would testify about the issue.

The purpose of having the claimant's physician send a copy of his or her records to the employer no later than 48 hours prior to the arbitration hearing is to prevent the claimant from springing surprise medical testimony on the employer. *Ghere,* 278 Ill.App.3d at 845, 215 Ill.Dec. 532, 663 N.E.2d 1046. In this case, Respondent had all of the records of Dr. Hansen as well as all of the records of Dr. Nord with unique knowledge of same as Respondent had referred Petitioner to Dr. Nord. The court in *Homebrite Ace Hardware v. Industrial Com'n,* 351 Ill.App.3d 333, 814 N.E.2d 126Ill.App. 5 Dist.,2004 found that *Ghere* should not be construed strictly without looking at the circumstances. In *Homebrite*, the court stated the following

> Here, employer contends that the Commission cannot arbitrarily determine when an opinion constitutes surprise testimony. It suggests that the Commission must strictly adhere to *Ghere* and thus any undisclosed opinion testimony must be deemed as surprise and be barred. Employer argues that it would be unduly burdensome for a court to have to regularly inquire as to what parties expect an opposing witness to testify to in order to guarantee no surprise. We disagree.
>
> We find no indication in *Ghere* that its holding must be so strictly interpreted. The *Ghere* court examined the physician's records and treatment history to determine whether the employer was put on notice regarding the possibility that the physician might provide causation testimony. The court did not set forth a bright-line rule or presumption that undisclosed opinion testimony constitutes surprise. Furthermore, *Ghere* is factually distinguishable because the physician in *Ghere* had never treated the employee's heart condition, whereas Dr. Heffner did treat claimant for his neck problems. Dr. Heffner's records contain details about his treatment of claimant's neck complaints and therefore the records put employer on notice that Dr. Heffner might testify as to a causal relationship between the neck condition and claimant's work accident. Indeed, the only contested issue at arbitration was claimant's cervical injury. Employer's suggestion that Dr. Heffner's testimony should have been excluded is not well taken under these facts.

In the present case, Dr. Hansen was a treating physician who undertook care of Petitioner's right knee condition. The sole issue in the case was need for treatment and causation of Petitioner's knee condition.

Respondent was not surprised the day of the hearing but learned of Dr. Hanson's opinion on causation of Petitioner's right knee on May 14, 2014 with the Arbitration hearing taking place on March 17, 2015. The Arbitrator finds the testimony of Dr. Hansen is allowed.

Notwithstanding the above ruling, the Arbitrator is not persuaded by Dr. Hansen's opinion that a casual relationship existed based on an aggravation basis. Dr. Hnasen did not know anything about Petitioner's pre-existing condition when he first saw Petitioner in August of 2013. He did not know anything about the treatment with Dr. Larry Nord and has never reviewed an MRI of Petitioner's right knee. Prior to the date of his deposition, Dr. Hansen was unaware of a claimed injury date of September 15, 2010. The Arbitrator notes that although Dr. Hansen's initial office notes indicate the matter was work related and a "Patient Information Record" prepared by Petitioner show he indicated that his job as a "press operator" contributed to his pain, an "Insurance Information" form also completed by Petitioner, indicate that his injury was not work related. Dr. Hansen apparently submitted his surgical recommendation to Petitioner's group health carrier, Blue Cross BlueShield of Tennessee. The paperwork completed by Petitioner for Dr. Hansen's examination, suggests Petitioner's condition was not work-related and the bills were to be submitted to Blue Cross Blue Shield.

Dr. Hansen repeatedly testified that Petitioner had pre-existing degenerative arthritis in the knee. He admitted that whatever occurred in September of 2010 did not cause the arthritis. He could not point to any findings which would be the result of that activity confirming an aggravation, acceleration or exacerbation. The doctor admitted that the only condition he intended to address with the total knee replacement was the underlying arthritic condition and that condition pre-dated the claimed injury of September 15, 2010. He admitted that in reviewing the records of Dr. Novotny that a total knee replacement, had been discussed with the Petitioner at least as early as November of 2002. Given the findings of Petitioner's knee in 2001, he was not at all surprised that twelve years later, he may need a total knee replacement. He testified that same could occur with or without trauma, simply as a result of the underlying disease, degeneration process.

With respect to Dr. Hnasen's statement that Petitioner's knee condition is the result of working at the Company for 33 years. That opinion has little if no merit insofar as the Commission previously found in 2007 that Petitioner's right knee complaints and conditions were not the result of an injury or activity occurring at work.

Petitioner's own testimony undermines his claim. Petitioner provided previous testimony in 2005 wherein he testified that he had significant ongoing problems with his right leg that had not resolved. Petitioner, as of that date, clearly had problems, symptoms and complaints involving his right knee.

Petitioner was repeated questioned whether or not he had been advised prior to 2010 that he needed to have a knee replacement. The records from Dr. Novotny clearly reflect that those discussions occurred at least eight years prior to Petitioner's claimed injury in September of 2010.

Petitioner underwent surgery for his right knee condition in December of 2001. He was off work for a period of time and then returned to regular duty. He described his job at that time as requiring him to walk five miles a day, bending, stooping, lifting, pushing, pulling, carrying and climbing. He testified that the job changed after the injury but before he testified in November of 2005. The arbitration transcript clearly reflects that as of November 11, 2005, Petitioner performed the job of press operator. This is the exact job he performed on September 15, 2010 and the job he performed up to the date he retired, May 30, 2013. The Petitioner admitted that after the alleged September 15, 2010 injury, he continued working and did not miss any time from work through May 30, 2013. He admitted that not only did he continue working, but he continued working without any limitations, restrictions or change in the way he performed his job. Petitioner admitted that

he stopped working on May 30, 2013 for an unrelated condition. Furthermore, Petitioner was questioned whether or not in 2004 he put off any further treatment or surgery which had been discussed because he did not want to take time off work. Petitioner admitted that he did not want surgical treatment for the right knee at that time as he did not want to take any further time off work.

Based on the above, the Arbitrator finds that as a result of the accident sustained, Petitioner sustained a temporary aggravation of his right knee condition which had resolved as of January of 2011. After reviewing Petitioner's testimony, reviewing the medical reports and records and deposition transcripts, the Arbitrator further finds that Petitioner failed to prove that the knee replacement currently being recommended is not causally connected to the accident sustained on September 15, 2010. For this reason, the Arbitrator denies Petitioner's 19(b)/8(a) request for prospective medical.

With exception to evidentiary issues, all remaining issues are moot.

Regarding Issue (O) Evidence Rulings - Did Respondent have authorization to request a causal connection opinion from Dr. Nord?

Dr. Nord, the Company doctor, who had been Petitioner's treating physician most immediately following the claimed date of accident, in his January 31, 2013 note to Respondent stated:

> The patient previously had undergone right knee arthroscopic debridement by Dr. Novotny in 2005. This patient has underlying osteoarthritis, which is not work related. However, the extent of his knee arthritis has progressed to the point now where he probably needs to undergo right total knee replacement. There is no causal connection of the patient's bilateral knee arthritis regarding his work at Bridgestone/Firestone.

Petitioner's attorney's objection to the doctor's opinion under the *Petrillo* is misplaced. In *Hydraulics-v-Industrial Commission* 329 Ill.App.3d 166, 169-170, 768 N.E.2d 760, 76, 263 Ill.Dec. 679, 682 (Ill.App. 2 Dist.,2002) the Appellate Court wrote:

> To hold a workers' compensation claimant, by virtue of filing an Application for Adjustment of Claim, waives his or her physician-patient privilege flies in the face of the public policy announced by the Illinois Appellate Court in *Petrillo,* and more recently, the Illinois Supreme Court in *Best.*"
>
> On March 2, 1999, a hearing was held before the arbitrator pursuant to remand from the Commission. The arbitrator took Pencak's testimony wherein she admitted that she had not sought claimant's permission prior to communicating with Dr. Ruder. At this hearing, the arbitrator again excluded the new job description and Dr. Ruder's revised opinion, but admitted the video tape.

In this case Petitioner gave a signed release allowing Respondent to contact his treating physicians "including, but not limited to" his original treating physician. (Respondent's Exhibit 7A.) He also executed for Dr. Nord a form specifically allowing the doctor to communicate "relevant information on the Patient's medical record" with to insurance companies and other third party payers. A causal connection opinion is "relevant information on the Patient's medical record" in a Workers Compensation setting.

The pertinent portions of the release signed by the Petitioner on September 21, 2010 states:

PAYMENT AGREEMENT/CONSENT/INSURANCE ASSIGNMENT/RELEASE

Release of information: The Signer hereby consents that relevant information on the Patient's medical record and (when specially requested) copies of any pertinent medical record information may be given to any insurance company or other third party payer for the sole purpose of securing payment of the Patient's bills.

WORKER'S COMPENSATION

I understand that I am responsible for any charges incurred due to the treatment of my medical condition. In addition, I also understand that Central Illinois Orthopedic Surgery IL, L.L.C. (CIOS), also d/b/a Neuro Ortho Rehab Center, will make a diligent attempt to retrieve payment for services provided to me from the workers' compensation insurance company in cases that have been deemed to be covered by workers' compensation insurance. If my case in not deemed to be covered by workers' compensation insurance, I understand that I am expected to follow the guidelines set forth in the "Payment Agreement/Consent/Assignment/Release" section of this form.

As Bridgestone/Firestone has been granted the privilege of being self-insured by the Workers Compensation Commission it is such a third party payer. As the employer in a Workers' Compensation claim one of the precursors of the employer paying the doctor's bill for the treatment alleged to be necessitated by the injury is a determination as to whether or not there was a causal connection between the alleged injury and the condition of ill-being. Therefore answering the casual connection question is clearly part of the doctor's making, "a diligent attempt to retrieve payment for services provided to Petitioner" from the workers' compensation insurance company in cases that have been deemed to be covered by workers' compensation insurance." The two signed releases distinguish this matter from *Hydraulics* and Petitioner's attorney's objection under *Petrillo* is therefore overruled and the January 31, 2013 report is therefore admitted.

16IWCC0390

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

Thomas Crawford,
Petitioner,

vs.

NO: 11WC 33040

16IWCC0391

State of Illinois/Pinckneyville Correctional Center,
Respondent,

DECISION AND OPINION ON REVIEW

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

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

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

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

DATED: JUN 14 2016
o060716
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

CRAWFORD, THOMAS Case# **11WC033040**

Employee/Petitioner

SOI/PINCKNEYVILLE CORRECTIONAL CENTER **16IWCC0391**

Employer/Respondent

On 5/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

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

MAY 20 2015

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Thomas Crawford
Employee/Petitioner

v.

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

Case # **11** WC ~~**33404**~~ 33040

16IWCC0391

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 18, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0391

FINDINGS

On the date of accident, **May 4, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**57,020.00**; the average weekly wage was $**1,096.54.**

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Petitioner failed to prove he sustained an accident on May 4, 2011 that arose out of and in the course of his employment or that his current condition of ill-being is causally related to said accident. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

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

Signature of Arbitrator

5/11/15
Date

ICArbDec19(b)

MAY 20 2015

Thomas Crawford v. State of Illinois/Pinckneyville Correctional Center, 11 WC 033040

Petitioner filed an application for adjustment of claim with the Illinois Workers' Compensation Commission. Petitioner alleged that he sustained injuries to his bilateral hands and bilateral arms as a result of repetitive duties while working for Pinckneyville Correctional Center. Petitioner has alleged the date of accident as May 4, 2011. This is a repetitive trauma claim and the issues in dispute are accident, notice, causation, medical bills, and prospective medical.

Petitioner was 53 years old on May 4, 2011, which is his alleged manifestation date for his repetitive trauma claim. Petitioner testified that he worked as a Correctional Officer at Pinckneyville Correctional Center from November 1998, until he retired on November 1, 2014.

On July 30, 2010, Petitioner presented to Dr. John Krause at the Orthopedic Center of St. Louis for right ankle pain and completed a "Work History" questionnaire. (RX11) Petitioner was asked to describe his job in detail, and was further asked "What do you do with your hands and arms at work?" Petitioner wrote "Some key turning for cell doors and lifting of food carts upstairs during lockdowns." Petitioner was asked, "How often do you do these activities?". Petitioner responded, "Sporadically". Petitioner also reported that he had a second job as an "on call firefighter". Petitioner added that he was currently working his regular job and that his "current assignment allows sitting in a chair much of the time".

On January 1, 2011, Petitioner presented to Dr. Amar Sawar at the Neurology and Arthritis Clinic with complaints of joint pain. (RX12) Dr. Sawar noted Petitioner had a history of psoriasis, diabetes mellitus type 2, and hyperlipidemia. Dr. Sawar reported that Petitioner had been complaining of joint pain since 2011 involving both hands, both wrists, and both hips. In addition, he had complained of joint swelling involving both hands and wrists. Dr. Sawar also noted that Petitioner had been complaining of non-radiating neck pain for the past two years. Dr. Sawar reported that Petitioner had nerve conduction studies and EMG in the past which showed bilateral ulnar neuropathy and bilateral carpal tunnel syndrome. On physical exam, Dr. Sawar noted Petitioner had swelling +1 and tenderness +1 of all MCP's and PIP's of both hands and both wrists. Tinel and Phalen signs were negative bilaterally. Dr. Sawar assessed Petitioner with: 1) Psoriatic arthritis, 2) Peripheral neuropathy, 3) Bilateral carpal tunnel syndrome, and 4) Bilateral ulnar neuropathy.

On April 6, 2011, Petitioner presented to Marilyn Starkey, PA-C at Christopher Rural Health. (PX3) Petitioner reported an acute and gradual onset of neuropathy. Petitioner reported the numbness was in his bilateral arms and in his bilateral legs. Petitioner reported that the problem occurred constantly. Ms. Starkey noted that the context included hypertension. Petitioner also reported a sudden onset of arthalgias. Petitioner reported that the location was his bilateral knees and that the pain was aching, burning, and throbbing.

On April 20, 2011, Petitioner presented to Ms. Starkey. (RX12) Petitioner presented for a follow up of the weakness in his extremities. Ms. Starkey noted Petitioner was told to hold off on Lipitor for several months to see if the weakness had improved. Petitioner reported that he had been off the medication for several weeks and had no improvement so far.

On April 21, 2011, Ms. Starkey referred Petitioner to Herrin Hospital for an Initial MNT for Petitioner's diagnosis of Type 2 uncontrolled diabetes. (RX12) Ms. Starkey noted Petitioner had complications/comorbidities of hypertension and dyslipidemia.

On May 4, 2011, Petitioner underwent a nerve conduction study performed by Dr. Fakhre Alam. (PX4) Dr. Alam reported an impression of mild to moderate bilateral ulnar neuropathy at the elbow and mild bilateral carpal tunnel syndrome. Dr. Alam noted there was no evidence of lumbar radiculopathy on either side, and there was no evidence of peripheral neuropathy involving the lower extremities on either side.

On August 1, 2011, Petitioner presented to Ms. Starkey for complaints of musculoskeletal pain. (RX12) Petitioner reported the onset of his pain was three months ago and that it occurred constantly. Petitioner reported that there had been no injury. Petitioner reported symptoms of decreased mobility, difficulty initiating sleep, joint tenderness, nocturnal awakening, and tingling in his arms. Ms. Starkey assessed Petitioner with elbow and shoulder pain and planned to obtain a nerve conduction study from Dr. Alam and mail a copy to the Petitioner for an orthopedic appointment in St. Louis, MO.

On August 10, 2011, Petitioner presented to Ms. Starkey with complaints of nerve pain. (RX 12) Petitioner reported that over the last three months the pain in his right shoulder, arm and wrist had worsened. Petitioner also reported that his left thumb was warm and tender and swollen for the last few months. Petitioner reported the pain in his left thumb had increased in the past week. Petitioner was given a trial of Lyrica and a Medrol dose pack for the swelling in his left thumb and uric acid level.

On August 17, 2011, Petitioner presented to Dr. George Paletta with complaints of bilateral upper extremity pain and weakness. (PX5) Petitioner reported his chief complaints were of weakness, numbness, and arm pain involving both upper extremities. Petitioner gave a history of working as a correctional officer at Pinckneyville Correctional Center, and Dr. Paletta noted that Petitioner came in with a written history of "repetitive motion injury". Dr. Paletta noted that "[e]ven in this written description, he does not specifically related (sic) to any particular injury or activities." Petitioner advised that his symptoms of weakness and numbness began in March. Petitioner denied any significant pain related to his shoulders and wrists. Petitioner complained mainly of discomfort in the medial aspects of both elbows with radiation down to the lateral border of the forearms with some numbness and tingling into the hands. Dr. Paletta noted that Petitioner had no clinical signs of carpal tunnel syndrome. Dr. Paletta recommended repeating the EMG and nerve conduction studies because Petitioner's previous

study was not done with temperature correction. Dr. Paletta recommended night splints for presumed cubtial tunnel syndrome while awaiting the repeat study.

Petitioner provided Dr. Paletta with a "Reptitive Motion Injury" document that was referenced in Dr. Paletta's August 17, 2011 note. (PX5) Petitioner noted that as a wing officer he was required to key and pull open in excess of a hundred heavy steel doors daily, and then push them shut. Petitioner noted that he spent two to four hours a day performing that activity. Petitioner reported that when the facility was on lockdown he was required to key open hundreds of food slots (chuckholes) to feed the inmates in their cells. Petitioner reported that he had responded to dozens of fights between inmates and also assaults by inmates on staff. Petitioner noted that when assigned to gun tower #7 he had to climb down into and back up the tower on a vertical iron ladder, often doing so several times a shift. Petitioner reported that when assigned to the segregation units he would have to use handcuffs or waist chains when moving inmates.

On August 18, 2011, Petitioner underwent a nerve conduction study with Dr. Daniel Phillips. (PX6) Dr. Phillips noted Petitioner had a three to six month history of progressive sharp/aching pain in elbows, wrists and hands, with numbness in the last two fingers. Dr. Phillips further noted that Petitioner had severe pain in the left thumb which might have been related to gout. Petitioner reported neck pain without radiation. Dr. Phillips diagnosis was of mild demyelinative ulnar neuropathies across the elbows. The study was not impressive for carpal tunnel syndrome.

On August 22, 2011, Dr. Paletta reviewed the nerve conduction study performed by Dr. Phillips. (PX5) Dr. Paletta noted that Petitioner was on Lyrica and Prednisone for a presumed gouty attack of the left thumb. Dr. Paletta recommended Petitioner continue night splints and to transition to Aleve once he completed his prednisone taper. Dr. Paletta advised he would see Petitioner back in six weeks, and that if Petitioner had not improved he might ultimately require an ulnar transposition. Dr. Paletta did note that some features of Petitioner's symptoms suggested neurogenic pain, but of cubital tunnel etiology. Dr. Paletta stated Petitioner's primary care physician must have thought similarly which was likely the reason Petitioner was prescribed Lyrica.

On October 5, 2011, Petitioner presented to Dr. Paletta in follow up. (PX5) Petitioner reported that the night splints helped his night time symptoms significantly, but not his symptoms during the day. Dr. Paletta diagnosed Petitioner with chronic recalcitrant bilateral cubital tunnel syndrome, right greater than left, and mild right elbow lateral epicondylitis. Dr. Paletta advised that Petitioner had failed nonsurgical treatment. Dr. Paletta recommended an ulnar nerve transposition, and planned to do the right elbow first. Dr. Paletta recommended an MRI scan of the elbow be completed prior to surgery. If the MRI demonstrated significant lateral epicondylitis he would recommend concomitant partial lateral epicondylectomy. Dr. Paletta advised he would schedule the procedure at Petitioner's convenience and follow up with him to discuss the results of the MRI scan before the planned surgical date.

On August 31, 2011, Petitioner presented to Ms. Starkey. (RX12) Ms. Starkey noted that Petitioner presented with gout, and that his uric acid level was slightly elevated at 8.1. Petitioner reported that the Medrol dose pack had helped a lot. Petitioner was only on daily prednisone at that time. Petitioner reported that he had seen an orthopedic doctor and had hand splints that he was to wear for the following six weeks. Ms. Starkey prescribed Petitioner Allopurinal 300mg for his diagnosis of gout.

On September 14, 2011, Petitioner presented to Ms. Starkey for a follow up on his gout. (RX 12) Petitioner stated that his condition was worsening and described the pain as sharp and throbbing. Ms. Starkey noted Petitioner's left thumb was erythematous, warm and tender. Petitioner was prescribed prednisone and uloric.

On December 7, 2011, Petitioner presented to Ms. Starkey for musculoskeletal pain and psoriasis. (RX12) Petitioner reported that he had bilateral hand pain and the pain in his left thumb was worse. Petitioner also stated his psoriasis symptoms were poorly controlled and complained of bilateral hand pain due to that. Ms. Starkey noted Petitioner had a psoriasis flare up on his scalp, left elbow, and right ankle. Ms. Starkey planned to refer Petitioner to a dermatologist and to call Dr. Sawar to see if he could see Petitioner sooner than January 2012.

On February 1, 2012, Petitioner presented to Ms. Starkey for follow up on his hyperlipidemia and psoriatic arthritis. (RX12) Ms. Starkey noted Petitioner was diagnosed with psoriatic arthritis by Dr. Sawar and had started on Methotrexate.

On February 28, 2012, Petitioner presented to Dr. Sawar in follow up. (RX12) Petitioner reported that joint pain, swelling, and stiffness had dramatically improved. On physical examination Petitioner had 5/5 strength in all extremities. The joint examination showed swelling +1 and tenderness +1 in both wrists. Dr. Sawar diagnosed Petitioner with psoriatic arthritis that was clinically improving and a B12 deficiency. Petitioner was to increase his Methotrexate, continue folic acid, and taper prednisone.

On March 27, 2012, Petitioner presented to Dr. Sawar in follow up. (RX12) Petitioner reported with complaints of pain and swelling of MCP's and PIP's of both hands. Petitioner's joint exam showed swelling +1 and tenderness +1 of all MCP's and PIP's of both hands. Petitioner was given an increased dosage of Methotrexate.

On June 5, 2012, Petitioner presented to Dr. Sawar in follow up. (RX12) Petitioner complained of joint pain and swelling in spite of taking 5 tablets of Methotrexate 2.5 mg weekly. Petitioner reported he had morning stiffness that lasted 1-2 hours. Dr. Sawar assessed Petitioner with psoriatic arthritis with active synovitis and a B12 deficiency. Petitioner's dose of Methotrexate was increased.

On September 25, 2012, Petitioner presented to Dr. Sawar in follow up. (RX12) Petitioner reported that his joint pain and swelling had improved and that he was no longer

taking Prednisone. Petitioner was diagnosed with psoriatic arthritis, cervical disc bulging, and a B12 deficiency.

On August 12, 2013, Petitioner underwent x-rays of his bilateral hands and bilateral wrists. The impression of Petitioner's right and left hand x-rays were of mild osteoarthritis at the first carpal metacarpal joint on each hand. The impression of Petitioner's right and left wrist x-rays were of mild osteoarthritis of the first carpometacarpal joint on each wrist.

Petitioner followed up with Dr. Sawar on October 1, 2013, and December 3, 2013. Each time Petitioner was assessed with psoriatic arthritis, neck pain with cervical disc bulging, and a B12 deficiency.

Dr. James Williams testified via evidence deposition on February 26, 2014 regarding the records review he performed on Petitioner. (RX10) Dr. Williams testified that he is a board certified orthopedic surgeon with a Certificate of Added Qualification in the hand and upper extremity surgery. (RX10, pgs. 5-6) Dr. Williams testified that he reviewed medical records from Marilyn Starkey, medical records from Dr. Paletta, a nerve conduction study from Dr. Alam, a nerve conduction study by Dr. Phillips, job analysis reports and DVDs from Corvel, and a key estimation study performed by Lt. Jason Thompson. (RX10, pgs.11-19) Dr. Williams testified that he had toured Pinckneyville Correctional Center on July 12, 2011. (RX10, pg. 12) Dr. Williams testified during that tour he performed job duties that a correctional officer performs, specifically the activities of key turning, opening a chuckhole with a Folger Admas key, opening a cell door with a smaller key, handling and manipulating property boxes, handling trays in dietary, and operating handcuffs. (RX10, pgs.12-13)

Dr. Williams testified that the condition of diabetes could cause the condition of carpal and cubital tunnel syndrome, because diabetes affects the blood supply of the nerve. (RX10, pg. 14) Dr. Williams also testified that gout could predispose a person to carpal and cubital tunnel syndrome because it is a type of inflammatory arthritis which predisposes one to peripheral neuropathies. (RX10, pg. 14) Dr. Williams also testified that age and weight could predispose someone to the development of carpal and/or cubital tunnel syndrome. (RX10, pg. 15) Dr. Williams also testified that riding a motorcycle could also predispose a person to the development of carpal and/or cubital tunnel syndrome because it involves vibration which has been found to be the most significant factor in the development of neuropathies. (RX10, pg. 19)

Dr. Williams testified that, from what he observed, Petitioner's job duties were not repetitive or vibratory in nature. (RX10, pg. 20) Dr. Williams testified that based upon a reasonable degree of medical certainty he did not believe that Petitioner's job duties caused or aggravated his upper extremity condition. (RX10, pg. 21) Dr. Williams noted that Petitioner's complaints to Dr. Alam of a tingling sensation in his lower extremities were possibly indicative of an early neuropathy from diabetes. (RX10, pg. 22)

Dr. Paletta testified via evidence deposition on January 29, 2015. (PX7) Dr. Paletta testified that 60% of his practice was about the shoulder, 20% about the elbow and the rest of the upper extremity, and 20% was about the knee. (PX7, pg. 5) Dr. Paletta testified that he does not have a certificate of added qualification for hand surgery. (PX7, pg. 31)

Dr. Paletta testified that when Petitioner initially presented to him he brought a typed document describing his symptoms and condition which Petitioner described as a repetitive motion injury. Dr. Paletta testified that he also had Petitioner's EMG and nerve conduction study performed prior to August 17, 2011. (PX7, pgs. 9-10) Dr. Paletta admitted on cross-examination that he did not review any medical records from Petitioner's primary care physician, Marilyn Starkey, nor did he review records from Dr. Sawar at the Neurology & Arthritis Clinc. (PX7, pg. 34)

Dr. Paletta testified that Petitioner described a five month history of bilateral upper extremity pain and weakness that had begun in March of 2011. (PX7, pg. 10) Dr. Paletta testified that when he examined Petitioner all the pertinent findings were related to his elbows, specifically the ulnar nerve. (PX7, pg. 12) Following a repeat nerve conduction study, Dr. Paletta testified that he diagnosed Petitioner with cubital tunnel syndrome in both elbows. (PX7, pg. 15) Dr. Paletta testified that Petitioner was on a Prednisone taper for his condition of gout, and he recommended that Petitioner complete the taper because Prednisone was also used to treat mild cubital tunnel syndrome. (PX7, pg. 15)

Dr. Paletta testified that he considered himself familiar with the job duties of a correctional officer at Pinckneyville. (PX7, pg. 18) Dr. Paletta testified that it was his understanding of Petitioner's job that he was a correctional officer and that he did the activities that a correctional officer did. (PX7, pg. 18) Dr. Paletta testified that based upon the job duties Petitioner listed in his Repetitive Motion Injury document, he believed pulling open in excess of 100 heavy steel doors daily and restraining a lot of inmates could contribute to the condition of cubital tunnel syndrome. (PX7, pg. 21) Dr. Paletta also testified that if Petitioner was lifting food carts that weighed in excess of 200 pounds a lot, then that could also contribute to Petitioner's condition. (PX7, pg. 22)

Dr. Paletta testified on cross-examination it is very important to have an accurate understanding of Petitioner's job duties when making a causation opinion. (PX7, pg. 41) Dr. Paletta testified that he had not reviewed Dr. Krause's records from his treatment of the Petitioner. (PX7, pg. 41) Dr. Paletta agreed that when Petitioner reported his job duties to Dr. Krause as "some key turning for cell doors and lifting of food carts up stairs during lockdown", and that he performed those tasks "sporadically", that would be inconsistent with what Petitioner reported to him. (PX7, pg. 42) Dr. Paletta further testified that if Petitioner told Dr. Krause that his "current assignment allows sitting in a chair much of the time", that would also be inconsistent with what Petitioner reported to him. (PX7, pg. 43)

Dr. Paletta testified on cross-examination that he did not know what shift Petitioner worked, what post he worked, or how long he worked at each post. (PX7, pg. 53-54) Dr. Paletta also admitted he did not know how many keys Petitioner was turning a day. (PX7, pg. 57) Dr. Paletta testified that if the cell doors are easy to open, that could affect his causation opinion. (PX7, pgs. 58-59)

Dr. Paletta testified on direct examination that Petitioner had risk factors that would predispose him to the development of cubital tunnel syndrome. (PX7, pg. 27) Dr. Paletta testified that Petitioner's age, obesity, condition of gout, and condition of diabetes were risk factors for the development of cubital tunnel syndrome and/or lateral epicondylitis. (PX7, pgs. 27-28) Dr. Paletta testified that Petitioner did not report having hypertension to him, but if he did have hypertension it was a recognized risk factor for peripheral compressive neuropathy. (PX7, pgs. 64-65)

On cross-examination Dr. Paletta testified that Petitioner never reported to him that he rode a motorcycle, but that the vibration from riding a motorcycle could be a risk factor in the development of cubital tunnel syndrome and lateral epicondylitis. (PX7, pgs. 44 & 52) Dr. Paletta testified that Petitioner never reported to him that he worked as a volunteer firefighter. (PX7, pg. 44) Dr. Paletta testified that he has treated firefighters and that certain elements of their job could increase the risk of developing cubital tunnel syndrome, specifically having to use instruments to break down doors and into buildings, controlling the water hoses, and climbing up and down ladders. (PX7, pgs. 44-45)

On cross-examination Dr. Paletta testified that in order to make an accurate diagnosis and to outline the best treatment the more information a doctor has the better. (PX7, pg. 33) Dr. Paletta also agreed that when making a causation opinion it was equally important to have the patient's accurate health history. (PX7, pg. 33) Dr. Paletta testified that if Petitioner's medical records indicated that in April 2011 he was referred out for treatment of Type 2 uncontrolled diabetes that would be inconsistent with what Petitioner had reported to him, and that it could certainly affect his causation opinion. (PX7, pgs. 34-35) Dr. Paletta testified that on Petitioner's intake questionnaire, Petitioner did not indicate that he had arthritis. (PX7, pg. 35) Dr. Paletta testified that if Petitioner was diagnosed with and treated for psoriatic arthritis in January 2011 then that would be inconsistent with what Petitioner told him, and that information could have affected his causation opinion. (PX7, pg. 35-36) Dr. Paletta also testified that a cervical disc condition could produce symptoms similar to cubital tunnel syndrome, but that an EMG and nerve conduction study could be used to differentiate whether Petitioner's symptoms were of cervical origin or peripheral origin. However, Dr. Paletta admitted that neither of Petitioner's nerve conduction studies tested all the nerves that originate from the cervical spine. (PX7, pgs. 36-39)

Dr. Paletta admitted on cross-examination that in August 2011, Petitioner never told him that any particular job activity brought about the onset of his symptoms. (PX7, pgs. 45-46)

Dr. Paletta testified that if Petitioner returned to him for treatment he would need to undergo a complete reevaluation, including a repeat physical examination. (PX7, pg. 28) Dr. Paletta testified that if Petitioner's exam findings were suggestive of persistent cubital tunnel syndrome then Petitioner would need a new EMG and nerve conduction study before considering additional treatment. (PX7, pg. 28)

Petitioner testified at arbitration on March 18, 2015. Petitioner testified that he worked as a correctional officer for Pinckneyville Correctional Center for 16 years until he retired on November 1, 2014. Petitioner testified that he began working at Pinckneyville CC in November 1998. On cross-examination Petitioner testified that when he began working at Pinckneyville CC it had just opened and was a brand new facility with brand new locks, doors, and hinges.

Petitioner testified that during his first five years working at Pinckneyville CC he worked on second shift from 3:00 p.m. to 11:00 p.m. Petitioner testified that he spent the remaining eleven years working on day shift from 7:00 a.m. to 3:00 p.m.

Petitioner testified that he spent the majority of his career working in the housing units, but also a significant amount of time in the small receiving segregation unit, and also some time in R5 segregation. Petitioner estimated that 75% of his time was spent in the housing units. He testified that the other 25% of the time he split between walk officer and other various assignments. On cross-examination Petitioner testified that while working as a walk officer he would not have used Folger-Adams keys or bar rapped. Petitioner also agreed that while working as a walk officer, unless the facility was on lockdown, he would only have to cuff an inmate if there was an altercation.

Petitioner testified that of the 75% of the time in spent in the housing units, 60-65% of that time was as a wing officer and there was some time he worked as a control pod officer. Petitioner testified that the other 15% of the time he worked in the segregation unit.

On cross-examination Petitioner testified that in general population, where he spent 60 - 65% of his time, chow lines were done via mass movement. He testified that mass movement meant that the control officer opened the cell door via touch screen in the control room. Petitioner estimated that 10% of the chuckholes in general population were difficult to use. However, Petitioner admitted that unless the facility was on lockdown he would not be using the chuckholes in general population. Petitioner agreed that on second shift, which he worked the first five years of his career, keying and inmate movement was done less often.

On cross-examination Petitioner testified that there were bars on the showers that he had to rap in general population. Petitioner testified that he was required to rap them every shift.

Petitioner testified that R5 segregation is the main segregation unit and had four wings. Petitioner testified that in segregation inmate services are delivered through a chuckhole which had to be keyed open. Petitioner testified that a Folger-Adams key was used to key open the

chuckholes. Petitioner testified that some chuckholes were easy to open but that most were not. Petitioner testified that the majority of the bars in segregation were on the showers. Petitioner testified that he bar rapped while working at Pinckneyville CC. Petitioner testified that doors were opened in segregation with a key that is a bit smaller than a Folger-Adams key. Petitioner testified that the cell doors were made of heavy steel.

On cross-examination Petitioner testified that he spent most of his time working in segregation in receiving segregation, or 'little seg'. Petitioner testified that in receiving segregation only 30 cells were actually segregation cells and 52 cells were receiving cells. Petitioner testified that when he worked in receiving segregation the cells were single occupant cells. Petitioner testified that the inmates in the receiving cells did not have to be cuffed for movement. Petitioner testified that in receiving segregation there were bars on the showers and a window. Petitioner testified that the bars were required to be rapped once per shift by the officer assigned to that wing. Petitioner admitted that while working in segregation he did have access to inmate porters. Petitioner testified that inmate porters would clean the showers, carry property boxes into a storage room, and assist with feeding the inmates. Petitioner also testified that during a feed other correctional officers would assist each other as much as possible.

On cross-examination Petitioner testified that some of his time working in segregation was as a control officer. Petitioner agreed that as a control officer he was using a touch screen and handing out keys, but he was not cuffing, bar rapping, or doing wing checks.

On cross-examination Petitioner testified that he would estimate about 10-20 percent of the chuckholes in segregation were difficult to open. However, Petitioner testified that Pinckneyville CC had a full time locksmith. Petitioner admitted that if he had a problem with a key or a chuckhole he could submit a work order for it to be repaired or replaced. Petitioner admitted that during his career at Pinckneyville CC he submitted a work order "maybe only a half a dozen times".

Petitioner testified that a wing check is done every 30 minutes. You circle the wing and check every single door by pulling on the handle to make sure that it is locked. Petitioner testified that the cell doors were heavy steel doors. On cross-examination Petitioner agreed that the doors were on hinges and that the majority of doors in general population were opened fairly easily with little force. Petitioner agreed that the segregation doors were also on hinges and that not every door was difficult to open.

Petitioner testified that a shakedown is when you search a cell top to bottom and go through the contents of an inmate's property box. Petitioner testified on day shift he was required to shake down one cell on his wing per shift, and on second shift he was sometimes asked to do two cells on his wing if they were running behind.

Petitioner testified that lockdown occurs due to a security breach, a fight between inmates, or an assault on staff members. As a result the inmates are secured in their cells.

Petitioner testified lockdown increased the duties of a correctional officer greatly. Petitioner testified that there are two levels of lockdown, level one and level four. On a level one lockdown there was not supposed to be any inmate movement so inmates were fed and received meds through the chuckhole. Petitioner testified that he had to deliver mail through the chuckhole. Petitioner testified that he also had to carry laundry, trash, and food carts up the stairs. Petitioner testified that he thought in 2010 there was a higher frequency of lockdowns.

On cross-examination Petitioner admitted that when the facility was on lockdown it did not affect his job duties in segregation. Petitioner testified that on a level four lockdown he was still able to use inmate porters. Petitioner also agreed that one area of the facility could be on lockdown while another would not be affected. Petitioner admitted that while the facility was on lockdown he could potentially be working in an area of the facility that was unaffected. Petitioner also admitted that on a level four lockdown the inmate porters would carry the laundry and food carts up the stairs.

Petitioner testified that he was required to cuff and uncuff inmates. Petitioner testified that during a lockdown, any time an inmate was moved he was cuffed. When the facility was not on lockdown, Petitioner testified that he had to cuff inmates after inmate fights or assaults on staff.

Petitioner testified that during the 16 years at Pinckneyville CC he opened thousands of cell doors, and opened thousands of chuckholes.

On cross-examination Petitioner testified that he reviewed the estimation of key usage at Pinckneyville CC that former Lt. Thompson generated, which is Respondent's Exhibit 6. Petitioner agreed that Lt. Thompson's estimation was "as close an estimation that anyone could arrive at".

Petitioner testified that he does not have gout, hypothyroidism, or rheumatoid arthritis. Petitioner testified that he has been told twice that he is prediabetic, but that he does not take any diabetes medication and that his condition is controlled by his diet.

On cross-examination Petitioner admitted that he was diagnosed with psoriatic arthritis in January 2011. Petitioner denied ever being referred to see a doctor for Type 2 uncontrolled diabetes. Petitioner testified that his family physician's records were inaccurate if they indicated such. When asked on cross-examination about his medical records indicating a diagnosis and history of treatment for gout, Petitioner denied ever being diagnosed with gout. Petitioner testified he was tested for gout, but they did not find gout. Petitioner admitted that he was prescribed medication for an inflammatory condition.

Petitioner testified that he collects guns, but does not shoot them often. Petitioner testified that he no longer rides a motorcycle because three years ago his elbow pain became too bad so he couldn't ride his motorcycle anymore. Prior to that, Petitioner testified that he rode his

motorcycle once a week to work and then he would ride it one or two evenings a week for an hour.

On cross-examination Petitioner testified that he experienced elbow pain while riding his motorcycle. Petitioner testified that his motorcycle was a Delux, and that while he was not sure the size of the motor "[i]t was a big one".

Petitioner testified that during the course of performing his job he began to develop pain and weakness in his arms and hands. Petitioner testified that he had a problem with dropping keys. Petitioner testified that he sought medical treatment on April 6, 2011, and was referred to Dr. Alam for a nerve conduction study. Petitioner testified that when the nerve conduction study was positive he called his attorney, Tom Rich, because he assumed his condition had to be related to work. Petitioner testified that the nerve conduction study performed by Dr. Alam was the first time anyone had tested him for carpal or cubital tunnel syndrome, and that was the first day he had been given the diagnosis.

On cross-examination Petitioner was asked about a patient intake questionnaire he completed for Dr. Krause which was in Respondent's Exhibit 11. Petitioner agreed that the document was written in his handwriting. Petitioner was asked about the disparity in the description of his job duties he gave to Dr. Krause and Dr. Paletta, specifically that Petitioner reported to Dr. Krause that he turned keys sporadically while he told Dr. Paletta that he turned hundreds of keys a day. Petitioner testified that "sporadic was still frequent use" but "[a]m I turning keys every minute of the day? No."

Petitioner testified that since his retirement he plays with his grandkids. Petitioner testified that he does not fish as much as he would like to because it hurts to cast. Petitioner testified that he is the assistant chief at his fire department and no longer fights fires.

On cross-examination Petitioner testified that prior to his retirement he was a volunteer firefighter for 17 years. Petitioner testified that as a volunteer firefighter he went out on calls. Petitioner admitted that he used power saws, axes, and a Halligan tool to break into doors and buildings. Petitioner testified that he averaged 70 calls per year.

Petitioner testified that since retirement his symptoms have not gotten better.

Major Jason Thompson was called in Petitioner's case in chief. Major Thompson testified that he is employed as a shift supervisor at Jacksonville Correctional Center. Major Thompson testified he worked at Pinckneyville CC from July 1998, until December 2011, and from December 2011, until March 2013, he worked at DuQuoin which is a satellite of Pinckneyville CC. Major Thompson testified that he knew the Petitioner because he was his direct supervisor from January 1, 2010, until December 2011. Major Thompson testified he was also Petitioner's direct supervisor for the first five years of Petitioner's career when he worked on second shift. Petitioner's counsel asked Major Thompson if Petitioner's testimony was

inaccurate in any way. Major Thompson testified that one inaccuracy stood out, specifically that there were no bars in general population housing units that had to be bar rapped.

Major Thompson testified that only one to two percent of chuckholes in general population were problematic, and only five to ten percent of chuckholes in segregation were problematic. Major Thompson was asked about the force required to push open cell doors and he testified that "I've seen the wind push doors open in general pop", and when asked how strong the wind was he replied "[n]ot very". Major Thompson agreed that during a wing check you would check the door with a flick of your wrist and you would hear the door catch. Major Thompson said if you were getting an indication from the control room that the door was open you might tug on it harder but a wing check by design can't take long. Major Thompson testified he could perform a wing check in five minutes or less.

Therefore, the Arbitrator concludes:

1. The Petitioner failed to prove he sustained an accident on May 4, 2011, that arose out of his employment with Respondent. Petitioner failed to prove that his condition of ill-being in his bilateral elbows is causally related to his alleged accident of May 4, 2011. Petitioner's testimony as to the job duties he performed was varied.

   Petitioner testified that he had worked numerous posts at Pinckneyville Correctional Center, and further testified to the different job duties required in each post that he had held. Dr. Paletta, Petitioner's treating physician, did not have a clear and accurate understanding of Petitioner's job duties for each post he held. At most, his opinion is based solely on Petitioner's representations to him without any type of objective analysis or understanding of his complete job duties. Dr. Paletta admitted that Petitioner did not even correlate his symptoms to his job duties. Dr. Paletta further testified that he did not know what shift Petitioner worked, what post he worked, or how long he worked at each post. Dr. Paletta also admitted he did not know how many keys Petitioner was turning a day. Dr. Paletta testified that if the cell doors are easy to open, that could affect his causation opinion

   "The Commission has determined that a claimant fails to prove causation from repetitive trauma when the treating physician testified repetitive motions causes the injuries but failed to detail what repetitive motions the petitioner engaged in and the frequency of the motions." *Phillips v Pinckneyville Correctional Center*, 10 WC 23567, citing *Gambrel v. Mulay Plastics*, 97 IIC 238.

   Additionally, Dr. Paletta did not have an accurate medical history from the Petitioner. Dr. Paletta testified that in order to form a causation opinion an accurate medical history is very important. Dr. Paletta testified that if Petitioner's medical records indicated that in April 2011, he was referred out for treatment of Type 2 uncontrolled diabetes, that would be inconsistent with what Petitioner had reported to him, and that it could certainly

affect his causation opinion. Dr. Paletta testified that on Petitioner's intake questionnaire, Petitioner did not indicate that he had arthritis. Dr. Paletta testified that if Petitioner was diagnosed with and treated for psoriatic arthritis in January 2011, then that would be inconsistent with what Petitioner told him, and that information could have affected his causation opinion.

Lastly, Dr. Paletta testified that Petitioner never reported to him that he rode a motorcycle, but that the vibration from riding a motorcycle could be a risk factor in the development of cubital tunnel syndrome and lateral epicondylitis. Dr. Paletta also testified that Petitioner never reported to him that he worked as a volunteer firefighter. Dr. Paletta testified that he has treated firefighters and that certain elements of their job could increase the risk of developing cubital tunnel syndrome, specifically having to use instruments to break down doors and into buildings, controlling the water hoses, and climbing up and down ladders.

Dr. Paletta lacks credibility in light of all the information he failed to obtain, and all the information Petitioner failed to provide, with regard to his work and medical history.

Dr. James Williams performed a records review on behalf of Respondent and testified via evidence deposition. Dr. Williams testified that he reviewed Petitioner's medical records, the Corvel Job Analysis reports and DVDs, and the key estimation study by Lt. Jason Thompson. Based upon the information, his knowledge and expertise, Dr. Williams opined to a reasonable degree of medical certainty that the job duties of a correctional officer at Pinckneyville Correctional Center did not cause or aggravate cubital tunnel syndrome.

2. Petitioner's claim for compensation is denied. All other issues are moot.

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

Tim Olson,

Petitioner,

vs. NO: 11WC 30587

John Deere Harvester,

Respondent,

16IWCC0392

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, notice, incurred medical, prospective 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 June 18, 2015, is hereby affirmed and adopted.

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

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

16IWCC0392

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: JUN 14 2016
o060816
CJD/jrc
049

Charles J DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OLSON, TIM
Employee/Petitioner

Case# **11WC030587**

13WC015492
11WC030588

JOHN DEERE HARVESTER
Employer/Respondent

16IWCC0392

On 6/18/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1381 JOHN MALVIK
224 18TH ST
4TH FLOOR
ROCK ISLAND, IL 61201

0077 BOZEMAN NEIGHBOUR PATTON & NOE
JOHN HARRIS
PO BOX 659
MOLINE, IL 61266

16IWCC0392

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

TIM OLSON
Employee/Petitioner

v.

JOHN DEERE HARVESTER
Employer/Respondent

Case # **11** WC **30587**

Consolidated cases: **13 WC 15492 and 11 WC 30588**

An *Application for Adjustment 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, the city of **ROCK ISLAND**, on **MAY 13, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 26, 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 **N/A** given to Respondent.

Petitioner's current condition of ill-being N/A causally related to the accident.

Order

The Petitioner failed to prove that he sustained an accident arising out of his employment with John Deere Harvester on May 26, 2010.

As such, the claim is denied.

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.

D. Dfan McCarthy June 8, 2015

JUN 18 2015

In support of the Arbitrator's decision relating to **(C) whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent**, the Arbitrator finds the following facts:

Petitioner, Timothy Olson, has worked primarily at John Deere Seeding Group (Seeding) since September 2003 as a welder. In 2010 and 2011, Petitioner would also work at John Deere Harvester Works (Harvester) rather than Seeding during the summer months. In the present case, Petitioner alleges that on May 26, 2010 he injured his right wrist while lifting and flipping over a part weighing approximately thirty (30) pounds. Petitioner testified that while working on a welding project at Harvester he had to load a fixture with steel and flip the steel part upside down. While doing that, Petitioner testified that he felt a sting and burn in his right wrist but kept working through July 1, 2010. Subsequent to that date, on July 2, 2010, Petitioner suffered an accident at home which resulted in two (2) factures in his left wrist. Because of the left wrist fractures, he was off of work at Harvester until August 25, 2010. When he returned, the welding project had ended, so he performed relief work which he described as light in nature. Petitioner worked at Harvester until September 17, 2010 and then returned to Seeding.

Petitioner testified that he told his supervisor, identified as Brian Kennedy, that he had hurt his wrist flipping a channel on the alleged date of accident. He said that he was not sent for medical treatment and that no accident report was completed. He thought he had strained his wrist and tried to work through it. He further testified that by July 1, 2010, his wrist pain had increased such that he told Brian that he could no longer perform his job due to pain. Again there was no evidence that he was referred for treatment. His left wrist was injured the following day.

Ben Ferguson, an occupational safety analyst for the Respondent, testified that no incident report was filed for the accident. He said that normally an incident report would be filled out by the employee, after going to the occupational health clinic at his supervisor's request. He further said that Brian Kennedy still worked as a supervisor for the Respondent Harvester.

Petitioner did not seek medical treatment until March of 2011. Specifically, Petitioner first reported pain in his right wrist on March 29, 2011 to Christina Dziuk, a nurse at Occupational Health Services. At the time, he stated that he first began to have symptoms when he was at Harvester last season and had been intermittent since then and he probably should have reported it earlier. Petitioner gave no information regarding a date of injury or the mechanics of this alleged single incident. The following day, on March 30, 2011 at Occupational Health Services, Petitioner told Dr. Christine Deignan that he had pain in his wrist that started while he was at Harvester, but could not give an actual date.

Petitioner saw his family doctor, Dr. Wenck, on August 17, 2010, November 22, 2010, and March 4, 2011 for various issues and never-reported a pain in his right wrist. Significantly, Petitioner saw Dr. Wenck for an annual physical examination on March 21, 2011 and made no mention of his right wrist pain.

When Petitioner was seen by Dr. Timothy Millea on June 8, 2010 at ORA Orthopedics for his left wrist pain, no complaints were made with regards to his right wrist. Throughout his care in the summer of 2010 at ORA Orthopedics for his left wrist fracture, no complaint was ever made or any information given concerning right wrist pain or an injury to the right wrist at work on May 26, 2010.

The Petitioner must prove by a preponderance of the evidence the various elements of his claim. Here, he testified to a specific accident, the existence of which is disputed by the Respondent. He did not present any evidence to corroborate his version of said accident. As stated above no accident report was filed. Though he claimed that his right wrist pain was continuous and progressive from the date of accident forward, he made no complaints about it to either his family physicians or orthopedic surgeon, whom he saw for his left wrist

problem. He did not produce any lay witnesses such as a family member or co-worker to support his claim that he had ongoing symptoms. There was no indication that he had subpoenaed Mr. Kennedy, who remained in the area working for the Respondent. In addition, there is nothing in the records of his treating doctors beginning with the note to John Deere medical on March 29, 2011 that he had an accident such as the one he described at arbitration. In fact, he saw Dr. Deignan, Dr. Ellis and Dr. Von Gillern, and had surgery, before any medical note appears which describes the alleged occurrence. When he finally did tell a provider about the specific event, it was to his physical therapist on June 20, 2011, long after his claim had been denied by the Respondent.

While both Dr. Ellis and Dr. Von Gillern did write that the injury was related to work, their opinions are not persuasive as pertaining to this claim. Dr. Ellis simply wrote that the Petitioner's work involved repetitive gripping and lifting, without reference to the specific accident or the work itself. Dr. Von Gillern simply said the work may have aggravated the conditions which he treated, again without explaining anything about said work.

Based upon the above, the Arbitrator finds that the Petitioner failed to prove an accident arising out of his employment on May 26, 2010, as alleged. The claim is denied.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tim Olson,

Petitioner,

vs. NO: 11WC 30588

John Deere Harvester,

Respondent,

16IWCC0393

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, notice, incurred medical, prospective 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 June 18, 2015, is hereby affirmed and adopted.

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

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

16IWCC0393

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: JUN 14 2016
o060816
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OLSON, TIM
Employee/Petitioner

Case# **11WC030588**

11WC030587
13WC015492

JOHN DEERE HARVESTER
Employer/Respondent

16IWCC0393

On 6/18/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1381 JOHN MALVIK
224 18TH ST
4TH FLOOR
ROCK ISLAND, IL 61204

2119 CALIFF & HARPER PC
STEVE NELSON
506 15TH ST SUITE 600
MOLINE, IL 61285

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

TIM OLSON
Employee/Petitioner
v.
JOHN DEERE SEEDING
Employer/Respondent

Case # 11 WC 30588

Consolidated cases: 11 WC 30587 & 13 WC 15492

16IWCC0393

An *Application for Adjustment 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 **Rock Island, IL**, on May 12, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 29, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being N/A causally related to the accident.

In the year preceding the injury, Petitioner earned $**48,952.28**; the average weekly wage was $**941.39**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **2** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

Denial of benefits.

Based on the evidence and the petitioner's testimony, the Petitioner failed to prove that he sustained an accident at John Deere Seeding on March 29, 2011. All other issues become moot.

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

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

D. Dylan McCarthy
Signature of Arbitrator

June 8, 2015
Date

JUN 18 2015

Tim Olson v. John Deere Seeding, Case Number 11 WC 30588.

In support of the Arbitrator's decision relating to whether an accident occur that arose out of and in the course of Petitioner's employment by Respondent the Arbitrator finds the following facts:

The Petitioner has filed an Application For Adjustment Of Claim alleging an injury to his right hand due to repetitive work activities at John Deere Seeding on March 29, 2011, Case Number 11 WC 30588. The Petitioner also filed two Applications For Adjustment Of Claims against John Deere Harvester Claim alleging an injuries to his right hand due to repetitive work activities at John Deere Harvester on May 26, 2010, and September 17, 2010, Case Numbers 11 WC 30587 and 13 WC 15492.

The Petitioner worked at John Deere Harvester from April 5, 2010 to September 20, 2010, and May 16, 2011 to September 12, 2011. Otherwise, he worked at John Deere Seeding, beginning in September of 2003.

At John Deere Seeding, the Petitioner welded sub-assemblies for planters. This was a much easier job than the job he was performing at John Deere Harvester on May 26, 2010. He testified that he used a hoist to lift while at Seeding, and that his work was not heavy in nature.

On May 26, 2010, the Petitioner testified that he felt a sting and burn in his right wrist while lifting a 30 pound part. The Petitioner further said that he did not have to lift 30 pound parts prior to working at Harvester on April 5, 2010.

On March 29, 2011, the date of the alleged accident at John Deere Seeding, the Petitioner reported to the nurse at the Medical Department that he first experienced discomfort in his wrist at John Deere Harvester; that it had started at John Deere Harvester the last building season; that it had been intermittent since; that he thought it would resolve on its own; and that he probably should have reported it earlier. The Petitioner did not report any incident at John Deere Seeding on that date.

On March 30, 2011, the Petitioner was seen in John Deere Seeding Medical Department by Dr. Deignan. He complained of on-going pain in his right wrist pain. He reported that it had started at John Deere Harvester, but he could not give an actual date. He did not report any incident at John Deere Seeding.

On April 27, 2011, he was seen again by Dr. Deignan. He reported that he developed problems at John Deere Harvester and had worked a whole season at John Deere Seeding before reporting it.

On May 2, 2011, he was referred to an orthopedic surgeon by John Deere Medical Group for right hand pain. He related it to injury at work last summer. In the summer of 2010, the Petitioner was working at John Deere Harvester, not at John Deere Seeding.

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

Tim Olson,

Petitioner,

vs. NO: 13WC 15492

John Deere Harvester,

Respondent,

16IWCC0394

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, notice, incurred medical, prospective 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 June 18, 2015, is hereby affirmed and adopted.

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

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

16IWCC0394

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:
o060816
CJD/jrc
049

JUN 14 2016

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OLSON, TIM
Employee/Petitioner

Case# **13WC015492**

11WC030587
11WC030588

JOHN DEERE HARVESTER
Employer/Respondent

16IWCC0394

On 6/18/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1381 JOHN MALVIK
224 18TH ST
4TH FLOOR
ROCK ISLAND, IL 61201

0077 BOZEMAN NEIGHBOUR PATTON & NOE
JOHN HARRIS
PO BOX 659
MOLINE, IL 61266

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

TIM OLSON
Employee/Petitioner

v.

JOHN DEERE HARVESTER
Employer/Respondent

Case # **13** WC **15492**

Consolidated cases: **11 WC 30587 and 11 WC 30588**

16IWCC0394

An *Application for Adjustment 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, the city of **ROCK ISLAND**, on **MAY 13, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 17, 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 N/A given to Respondent.

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

Order

Petitioner has failed to prove an accidental injury due to alleged repetitive trauma on September 17, 2010, and his claim is denied.

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

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

D. Dafna McCarthy
Signature of Arbitrator

June 8, 2015
Date

JUN 18 2015

In support of the Arbitrator's decision relating to **(C) whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent** and **(F) whether Petitioner's current condition of ill-being is causally related to the injury**, the Arbitrator finds the following facts:

Petitioner, Timothy Olson, has worked primarily at John Deere Seeding Group (Seeding) since September 2003 as a welder. In 2010 and 2011, Petitioner would also work at John Deere Harvester Works (Harvester) rather than Seeding during the summer months. In the present case, Petitioner alleges the date of injury of September 17, 2010 for repetitive trauma to his right wrist. In case number 11 WC 30587 Petitioner alleges a date of injury of May 26, 2010 for lifting and flipping a thirty (30) pound part. These two (2) cases against Harvester were consolidated for hearing along with case number 11 WC 30588 against Seeding.

Petitioner, in his testimony, alleged an injury to his wrist on May 26, 2010 while at Harvester. Petitioner failed to testify regarding any repetitive action at work, only testifying regarding the one (1) incident on May 26, 2010 which gave rise to pain. Petitioner gave no testimony regarding the number of times any action was performed in a shift or the nature of those activities other than the single incident on May 26, 2010. He did say that the weight was more than he would normally lift while working at Seeding. Petitioner also said that his wrist had remained sore since the original claimed accident of May 26. Petitioner continued to work at Harvester until an accident at home on July 2, 2010 fractured his left wrist. Petitioner was off work for the left wrist fracture until August 25, 2010.

Upon his return to Harvester on August 25, 2010, Petitioner did light duty work until his last day at Harvester on September 17, 2010. This work included tasks such as sweeping. The light duty work did not stress his hands or wrists according to Petitioner. No testimony was given regarding any repetitive action at Harvester during this time.

Petitioner first reported pain in his right wrist on March 29, 2011, sometime after he had returned to work at Seeding. He reported to the medical department at Seeding that he had pain in his right wrist which had been intermittent since the last build season at Harvester.

Petitioner saw Dr. Timothy Millea at ORA Orthopedics for his left wrist fracture on July 8, 2010 and never reported pain in his right wrist arising from a May 26, 2010 incident or from repetitive trauma. Petitioner also saw his family doctor, Dr. Todd Wenck, at John Deere Medical Group March 4, 2010, September 17, 2010, November 22, 2010, and March 29, 2011 for various matters. At neither of those visits did Petitioner report any pain in his right wrist. Finally, Petitioner had an annual physical with Dr. Wenck on March 21, 2011 and did not report any right wrist pain at that time either.

Petitioner began his treatment for his right wrist with Dr. Jessica Ellis at ORA Orthopedics on May 11, 2011. At that time, Dr. Ellis, in her work restrictions, stated "Must have a wrist brace on. He has an overuse, chronic wrist tendonitis that is work related." Dr. VonGillern on November 28, 2011 stated that he felt that "the patient's right wrist injury was not caused by an on the work job injury, but may have been aggravated by an on the work job injury". However, significantly, there is no evidence or proof that either doctor had any information about any repetitive work activities or repetitive trauma on behalf of the Petitioner at Harvester. As such, their opinions regarding causal connection are not persuasive.

The Arbitrator finds that there was no evidence either presented at hearing or in the exhibits received into the record that supports a finding that repetitive trauma on or about September 17, 2010 at John Deere Harvester Works caused any injury to Petitioner's left wrist.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel W. Niemeyer,

Petitioner,

vs. NO: 12 WC 37865

Randolph County Sheriff's Department,

16IWCC0395

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 16, 2015, 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.

16IWCC0395

The party commencing 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: JUN 14 2016
TJT:yl
o 6/7/16
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

NIEMEYER, DANIEL W
Employee/Petitioner

Case# **12WC037865**

RANDOLPH COUNTY SHERIFF'S DEPT/RANDOLPH COUNTY
Employer/Respondent

16IWCC0395

On 11/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4852 FISHER KERKHOVER & COFFEY
JORDAN D GREMMELS
1300 1/2 SWANWICK ST
CHESTER, IL 62233

0810 BECKER PAULSON & HOERNER PC
AARON J CHAPPELL
5111 W MAIN ST
BELLEVILLE, IL 62226

16IWCC0395

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Daniel W. Niemeyer
Employee/Petitioner

v.

Randolph County Sheriff's Dept./Randolph County
Employer/Respondent

Case # **12** WC **037865**

Consolidated cases: **N/A**

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **09/05/12**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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 $**44,365.04**; the average weekly wage was $**853.17**.

On the date of accident, Petitioner was **35** years of age, ***married*** with **0** dependent children.

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

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

Respondent is entitled to a credit of $**4,321.00** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove that he sustained an accident on September 5, 2012 that arose out of and in the course of his employment or that his current condition of ill-being is causally related to that accident or his employment duties. 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 8, 2015
Date

ICArbDec19(b)

NOV 16 2015

Daniel W. Niemeyer v. Randolph County Sheriff's Department/Randolph County
Case Number: 12 WC 037865 (19(b))

Findings of Fact and Conclusions of Law

Petitioner alleges repetitive stress injuries to his wrists and elbows which manifested on September 5, 2012. (AX 2)

The Arbitrator finds:

Petitioner has been working for Respondent in a full-time capacity since 2009. Petitioner alleges an accidental injury to his left and right wrists and left and right elbows as a result of repetitive trauma.

On December 10, 2009 Petitioner was seen by his primary care physician, Dr. Lisa Lowry-Rohlfing. She noted that he was being seen that date for secondary hypothyroidism related to previous pituitary surgery. He was experiencing weight gain and lack of energy. His weight was noted as 420 pounds. He was given a prescription for Ambien and his Synthroid was adjusted. (PX 4)

On March 11, 2010 Petitioner returned to Dr. Lowry-Rohlfing for a re-evaluation of mood disturbance. Petitioner's diagnoses of hypothyroidism and hypogonadism were noted. It was also noted that he was seeing an endocrinologist at Washington University for his continued issues with poor energy. He was on Synthroid and testosterone replacements as well as Zoloft and Ambien. He was interested in lap banding. Weight control had been an issue of his. Dr. Lowry-Rohlfing indicated that the last time Petitioner weighed under 300 pounds was in junior high. He had weighed as much as 450 pounds in the past. (PX 4)

On July 1, 2010 Petitioner returned to Dr. Lowry-Rohlfing for a re-evaluation of his hypothyroidism, hypertension and mood disturbances. He reported some right-sided knee pain after playing golf. X-rays revealed no fracture of dislocation of the right knee. (PX 4)

On August 12, 2010 Petitioner discussed the possibility of undergoing a sleep study with Dr. Lowry-Rohlfing. She opined that his hypertension and morbid obesity made him a high risk candidate of sleep apnea. Petitioner underwent the sleep study on August 17, 2010 and it was determined that he had severe sleep apnea. (PX 4)

On September 30, 2010 Petitioner followed up with his family physician to be reevaluated for hypertension, mood disturbance and sleep apnea. Petitioner reported that he was sleeping better after starting CPAP and had more energy and he was no longer nodding off at his computer at work. Dr. Lowry-Rohlfing noted Petitioner had

switched from drinking two liters of Mountain Dew per day to drinking Gatorade. (PX 4)

On December 28, 2010 Petitioner again saw Dr. Lowry-Rohlfing and his complaints were for hypertension, sleep apnea, and family issues. (PX 4)

On March 29, 2011 Petitioner returned to Dr. Lowry-Rohlfing. She noted that he was tired all the time and was having some right-sided hand pain and numbness worse when using his mouse doing any type of computer activity. Petitioner declined any testing for potential carpal tunnel syndrome. They discussed ways of potentially altering Petitioner's work station to improve function and alleviate pain. (PX 4)

Petitioner returned to see Dr. Lowry-Rohlfing on June 28, 2011, primarily regarding his ongoing issues and stress but no specific hand/wrist complaints were noted. Petitioner was having trouble with insomnia and was trying to switch positions at work to improve his level of stress. (PX 4)

On August 1, 2011, Petitioner was seen at Southern Illinois Spine and Joint Center in Sparta, IL by chiropractor Dr. Ryan Reiss. He presented with complaints of pain and discomfort in his upper thoracic, cervical, right trapezius/superior scapula, right posterior shoulder, right posterior arm, right posterior elbow, right posterior forearm, right posterior wrist and dorsum of the right hand. According to the office note, Petitioner's pain and discomfort began four months earlier and gradually got worse. The symptoms began after riding motorcycles. He reported that computer work increased his pain and anti-inflammatories decreased his symptoms. The pain was characterized as numb, tingling, aching, and sharp. The symptoms radiated to the right posterior shoulder, right posterior arm, right posterior elbow, right posterior forearm, right posterior wrist and dorsum of the right hand, and felt like a numb and tingling sensation. Objective findings were unremarkable. Dr. Reiss' assessment was cervical segmental dysfunction, cervicalgia, cervical radiculitis and/or brachial neuritis, myofascitis, thoracic segmental dysfunction, and thoracalgia. Cervical and thoracic manipulation and modalities were performed. (RX 4)

On August 16, 2011 Petitioner reported to Dr. Lowry-Rohlfing that he "did something" to his neck. The pain went up and down the right arm extending at times to his 1st and 2nd finger. His range of motion was full and his upper extremity strength was normal. She diagnosed him with cervicalgia with radiculopathy. (PX 4)

On August 18, 2011, Petitioner was seen at Memorial Hospital in Chester, Illinois. X-rays of the cervical spine were obtained. According to the radiology report, Petitioner had neck pain extending to the right arm. It revealed mild left-sided foraminal narrowing at C3-4 and 4-5 levels and at right C3-4 and 4-5. (PX 3)

On August 26, 2011 Petitioner presented to Memorial Hospital for an MRI. Prior to undergoing the diagnostic test, Petitioner noted on the prescreening forms that he had numbness and tingling in the right arm, hand and fingers. An MRI of Petitioner's cervical spine was obtained at 8/26/11. According to the radiology report, the impression was mild midline disc protrusion at C5-6, mild left paramedian disc protrusion at C6-7, and suspected mild right paramedian disc protrusion at T-2. (PX 3)

Petitioner spoke with Dr. Lowry's office regarding the MRI results on August 30, 2011. He advised the office he wished to hold off anything further as he was feeling better. (PX 4)

Petitioner returned to his family physician on September 27, 2011 reporting issues with low back pain. There was tenderness to palpation in the low back and limited range of motion mostly related to his body habitus. (PX 4)

Petitioner returned to Dr. Reiss on October 27, 2011. He complained of discomfort in the left sacroiliac joint, right sacroiliac joint, right lumbar spine, left lumbar spine, mid thoracic spin, left mid thoracic spine, left trapezius/superior scapula, upper thoracic spine, right trapezius/superior scapula and cervical region(s). Upon motion palpation, joint dysfunction was present. Movement analysis and soft tissue revealed asymmetrical loading across the joint. Dr. Reiss' assessment was cervical segmental dysfunction, cervicalgia, cervical radiculitis and/or brachial neuritis, myofascitis, thoracic segmental dysfunction, thoracalgia, lumbar segmental dysfunction, and lumbalgia. His prognosis was considered fair and chiropractic treatment was provided on that date.

Petitioner returned to Dr. Lowry-Rohlfing on December 27, 2011 for a re-evaluation of his hypothyroidism, hypertension, and mood disturbance. In general, Petitioner reported "doing well" albeit he was undergoing a lot of interpersonal stress. Petitioner also reported he was in the process of switching jobs as it would provide him with a better schedule. His medications were continued. (PX 4)

Petitioner began working as a correctional officer for Respondent in January of 2012. (RX 1)

On February 6, 2012 Dr. Lowry-Rohlfing ordered a prescription of 60 Hydrocone 7.5 mg for Petitioner. During this time Petitioner was dealing with some personal family issues and having trouble sleeping. (PX 4)

On April 17, 2012 Petitioner left a message for Dr. Lowry-Rohlfing requesting a replacement medication for a bulging disc and pain in his neck. She ordered Relafen for him. On May 21, 2012, it was noted that the Relafen was not helping his neck and hand pain. Meloxicam was ordered for him. (PX 4)

Petitioner returned to Dr. Lowry-Rohlfing on June 19, 2012. He reported severe pain in his neck and numbness in his right hand. He indicated that his left hand went numb as well. He had some decreased grip and difficulty with numbness and tingling. He was diagnosed with cervical radiculopathy and mood disturbance due to grief issues. He was to begin taking Trazodone 50 mg and Voltran 75 mg and discontinue Meloxicam. He was referred to physical therapy. (PX 4)

On June 20, 2012 Petitioner presented to Memorial Hospital for physical therapy and completed a Cervical Spine Evaluation/Treatment Plan. It was noted that Petitioner had neck pain and right upper extremity and hand pain. Petitioner described his job duties as "Opens/closes cells, paperwork." He reported being pain free until a few years earlier. In response to the question "Mechanism/History of Injury" Petitioner wrote: "Unknown. Pain primarily in right hand 3rd/4th digits and numbness/tingling, as well as wrist, forearm and elbow. Minimal neck discomfort, stiffness. These symptoms started while working as a dispatcher." Petitioner gave an onset date of "referred 6/19/12." Tinel's was negative at the elbow and wrist. The therapist's assessment was neck pain, radicular symptoms into the right upper extremity to the hand, and positive carpal tunnel tests. Physical therapy was initiated. (PX 3)

Petitioner was treated at Memorial Hospital on July 12, 2012. He complained of shortness of breath. He denied joint pain, muscle stiffness, back pain, neck pain, or upper extremity pain. Blood tests were obtained and showed a glucose level of 130. Thyroid studies were also performed. (PX 3)

Petitioner underwent physical therapy through July 17, 2012. (PX 3) Upon discharge the therapist noted that Petitioner's symptoms seemed more consistent with carpal tunnel syndrome. Progress had plateaued. (PX 3)

On July 17, 2012 Petitioner was re-evaluated by Dr. Lowry-Rohlfing for cervicalgia. It was noted that he had been undergoing physical therapy and there was some debate over whether his condition was radiculopathy versus carpal tunnel syndrome. His condition was not improving. A nerve conduction study was to be scheduled.(PX 4)

On September 6, 2012 Petitioner reported an injury to his supervisor. According to an Employee's Report of Injury, his "injury occurred from years of typing while performing telecommunications job duties." (RX1). Petitioner noted his left and right wrists and left and right elbows were affected. According to a Supervisor's Injury Report, his supervisor noted that Petitioner had not performed any telecommunicator duties since December of 2011. (Id.).

Petitioner signed his Application for Adjustment of Claim on September 11, 2012, alleging an accident date of September 5, 2012. (AX 2)

On September 12, 2012 Petitioner was evaluated by orthopedic surgeon Dr. Ryan Calfee for the primary complaint of right carpal tunnel syndrome. In the pre-evaluation forms, Petitioner noted that he was 6 feet 1 inches tall and 397 pounds. He reported carpal tunnel syndrome that had been present for approximately two years. He noted that typing, writing, and gripping made his pain worse. His medications included Diclofenac, Liothyronine, Montelukast, Levothyroxine, Trazadone, Astepro, Vitamin D, and Sertraline. He noted he smoked 1 ½ packs of cigarettes a day. His chief complaint was carpal tunnel syndrome. He presented with right hand numbness and tingling from the thumb through the long finger for the past two years. He also reported mild neck pain. His symptoms increased with writing and driving. It was noted he worked as a correctional officer. Petitioner reported his symptoms were intermittent. He advised Dr. Calfee he had a prior nerve conduction study and he was told he had carpal tunnel syndrome. X-rays were negative provocative sings at the carpal tunnel. He demonstrated negative provocative signs at the elbow and also with range of motion of the neck. Dr. Calfee noted that based on Petitioner's history and biologic diagnostic testing, he likely has carpal tunnel syndrome although his physical examination on that date was "not overly impressive." He wanted to review the nerve conduction study before making any recommendations.

Petitioner followed up with Dr. Calfee on October 17, 2012. Dr. Calfee had reviewed the nerve conduction study and noted it demonstrated carpal tunnel syndrome on the right side. Petitioner reported continued symptoms despite bracing. The doctor recommended a right carpal tunnel release. He also noted Petitioner's symptoms on the left were less severe and did not need to be addressed. Petitioner voiced his intent to file a workers' compensation claim. (PX 5)

On October 22, 2012 Petitioner was evaluated by Dr. David German with Midwest Plastic and Hand Surgery Injury Management Program at the request of Respondent. A report followed. (RX 9, dep. ex. 2) Dr. German took a history that Petitioner had worked for the Sheriff's Department for approximately three years and four months. He said that he started as a Dispatcher. In January 2012 he became a Correctional Officer. He said that as a Correctional Officer he worked at night many times by himself. Petitioner said he would work at a desk. He would monitor inmates, fingerprint inmates, book inmates and perform cell checks. He said much of what he did was based on the computer, although there was some typing and writing. Petitioner further said that when he was working as a dispatcher, he took approximately 20-25 calls a shift or about three calls an hour. Petitioner said that he worked part-time in Eavensville, Illinois as a patrol officer and that he worked about four hours a week there. Petitioner acknowledged being right-handed. Petitioner reported that the symptoms began in his right hand about two years earlier. He had minimal symptoms in the left hand. Petitioner complained of pain, numbness and

tingling in both hands. He said that he saw Dr. Lisa Lowry-Rohlfing in August 2011 for an injury to his neck. He said he developed pain with turning "in the wrong direction". He said that he was diagnosed with having radiculopathy and cervicalgia. He also has a history or hypothyroidism.

When Petitioner saw Dr. German he said that his numbness and tingling had progressed. He reported that his symptoms involved his thumb, index and long fingers primarily. He would awaken at nighttime and his symptoms would worsen while driving a car and talking on a phone. Bracing has not helped. The doctor noted that a nerve conduction study had been performed, but was unavailable. He noted that an MRI had been performed that showed two bulging discs in his neck and possibly a disc in the thoracic spine. Although he had an elevated blood glucose level, he said that there was no history of diabetes. He was taking thyroid medication for hypothyroidism. He also had high blood pressure. At the time, he was taking a number of medications including Liothyronine (a thyroid hormone used to treat hypothyroidism), Singulair, Diclofenac (a non-steroidal anti-inflammatory medication), Levothyroxine (a hypothyroid medication), Sertraline (a generic form of Zoloft, an antidepressant), Trazodone (an antidepressant that also has ability to treat anxiety, but can induce sleep), Astepro (a nasal spray for allergy symptoms) and Aleve.

Dr. German described Petitioner's physical examination as being rather benign. Dr. German diagnosed Petitioner's condition as numbness and tingling of his hands of an unknown etiology and noted that he had not had the opportunity to review the MRI or nerve conduction study. Dr. German felt that Petitioner's work was essentially sedentary with some computer use. Petitioner told him that he was sometimes able to read a book while working. He said there was no repetition, force or pressure that would count for his symptoms in his hands. He said that he had several risk factures for carpal tunnel syndrome, including his body weight (BMI at 52.1), hypothyroidism and elevated blood sugar levels. It was his opinion that Petitioner's work did not appear to be a contributing factor in the development of Petitioner's symptoms.

On December 12, 2012, Petitioner was seen by Dr. Lowry-Rohlfing with an interest in quitting smoking. He was smoking two packs per day. He was prescribed Chantix. (PX 2, RX 3)

On January 14, 2013 Petitioner was seen at Chester Clinic. His past medical history included hypothyroidism, hypertension, hypogonadism, seizures, and mood disorder. He had a surgical history including right carpal tunnel syndrome, smoked two packs a day, and was taking Chantix. He was encouraged to stop smoking. (PX 2, RX 3)

On May 24, 2013 Petitioner returned to Dr. Calfee. He noted Petitioner's right carpal tunnel syndrome was getting worse. Upon physical examination Durkin's test was positive, Tinel's test was negative, and Phalen's test was equivocal with very faint symptoms produced. Dr. Calfee still recommended a right carpal tunnel release. (PX 5)

On December 3, 2013, Petitioner was seen by Dr. Lowry-Rohlfing for complaints associated with carpal tunnel syndrome. It was noted that Petitioner was smoking two packs per day. Palpation of the wrists revealed no particular tenderness or deformity. Petitioner's grip strength and pincher strength were adequate. Tinel and Phalen signs were positive. Dr. Lowry-Rohlfing referred him to Dr. Vaught for evaluation of carpal tunnel syndrome. Petitioner reported being seen by a surgeon in St. Louis who he was not completely satisfied with, that the doctor did not yet have Petitioner's nerve conduction study, and that he refused to examine him. Petitioner reported being told "initially" that he needed surgery but he wasn't ready to proceed until now.(PX 2)

On December 16, 2013, Petitioner saw Dr. Kevin Vaught with Regional Brain and Spine. In his history form, Petitioner said that he was being seen for carpal tunnel syndrome and that he had it for over two years. He claimed that an injury caused his problem. When asked the date of the injury, he put down "unknown". When he was asked where the injury occurred, he put down "unknown". He complained of numbness in his right and left hands and occasional numbness in the right elbow. He was working at the time. He listed his pain as 5/10 and his problem areas as his right hand, right elbow, and left hand. He further stated that he had undergone physical therapy at Chester Memorial Hospital for three months and one chiropractic treatment with Southern Illinois Spine and Joint Center. He said that he had been taking Diclofenac, DayPro and Naproxen for over two years. He stated that he had high blood pressure, depression, arthritis, thyroid disease, a brain tumor and seizures. In 1993 he underwent a craniotomy by a Dr. Kaufman. Petitioner had undergone a muscle biopsy of his left shoulder in 1995. Petitioner acknowledged that he was a smoker and a correctional officer. At the time of this visit, he was taking Vitamin D, Levothyroxine, Liothyroninne sodium, Naproxen, Sertraline, Trazadone, Testosterone and Cyanosobulmin. He would receive the testosterone and the Cyansobulmin through injections. Those were two times a month. When asked if he had experienced a problem with any of several conditions, he said that he had experienced recent weight gain and weight loss, ringing in his ears, joint pain, numbness, and sleep apnea. (PX 1)

When Dr. Vaught saw Petitioner on February 10, 2014 he prepared a note stating that he was seeing Petitioner at the request of Dr. Rohlfing. Petitioner complained of numbness and tingling in his hands bilaterally with the right being greater than the left for the last 2-3 years. He said that he was a correctional officer at the County jail and that he was often required to turn keys, type and write multiple reports during the day.

He said that these activities gradually worsened his complaints of numbness and tingling in both hands. He said that over the last two-three years he also had intermittent neck pain and said he had an imaging study that showed a "bulging disc" in the cervical spine. He felt some weakness of the grip strength as well. He said he had attempted rest, Naproxen, activity modification and a wrist splint on the right with no lasting improvement. He said that if he wore the wrist splint during the night he would have some improvement in his hand sensations. He rated his pain as 5/10. It was noted that he was 6'1" tall and weighed 387 pounds. He had a BMI of 51.24. Grip on the right was 4+/5 and 4+/5 on the left. He had loss of sensation to light touch and pinprick with regard to the median nerve distribution of the left hand. He had decreased sensation to light touch in the right hand on a global basis. He had muscle spasm in the right paracervical and right trapezius area. He was tender to touch in the right suboccipital and trapezius area. He had a positive Tinel's sign on the right and on the left. His impressions were cervicalgia, numbness and altered sensations. The doctor noted that Petitioner had a two to three year history of worsening numbness and tingling in his hands bilaterally and that sometimes the numbness would radiate into the mid-bicep region on the right side. Petitioner further reported that over the last 2-3 years he had undergone imaging of the neck due to intermittent neck pain which revealed a bulging disc in the neck. The doctor thought that the repetitiveness of Petitioner's job requirements included turning keys, writing and typing and that they had caused his possible carpal tunnel syndrome to worsen. He recommended an MRI of the neck to rule out any cervical pathology, as well as flexion-extension x-rays of the neck. He also recommended EMGs of the upper extremities. (PX 1)

On February 18, 2014, Petitioner underwent electrical studies on his upper extremities by Dr. Steven Mellies at the Southeast Hospital. The left hand was normal for testing of the median nerve. The right hand revealed mild to moderate motor and sensory delay across the wrist. Left ulnar nerve testing revealed a very mild decrease in the compound motor action potential amplitude. Mid-palm orthodromic sensory distal latencies were obtained of digits 2 and 3 of the left hand and there was a mild relative prolongation of digit 2. It was the doctor's impression that this study revealed right median carpal tunnel syndrome and very mild to early carpal tunnel syndrome on the left. Nerve conduction study of the left ulnar nerve revealed a mild decrease in the compound motor action potential amplitude. Nerve conduction study of the right ulnar nerve was negative. The EMG was normal for both arms.

X-rays of Petitioner's cervical spine were taken at Cape Radiology Group on March 17, 2014. They revealed degenerative disc disease at C2-3. An MRI was conducted at the same facility on the same date and this revealed a minimal posterior disc bulge at C2-3. At C3-4 there was a midline disc protrusion that flattened the cord anteriorly. The left foramen was moderately narrow due to degenerative changes. At

C4-5 there was moderate left foraminal stenosis due to degenerative changes. At C5-6 there was a posterior midline disc protrusion that indented the cord anteriorly. There was mild right and moderate left foraminal stenosis due to degenerative changes at that level. At C6-7 there was a left paracentral disc/osteophyte complex that flattened the anterior cord. There was a minimal posterior disc bulge at C7-T1. At T1-2 there was a small posterior disc bulge that caused moderate central canal stenosis. The doctor's impressions were multi-level cervical disc disease and facet arthropathy; multi-level cervical central canal stenosis; multi-level cord flattening and multi-level foraminal stenosis. (PX 6, RX 7)

On March 28, 2014 Petitioner saw Dr. Andrew Moore with Southeast Cancer Center. He told the doctor that he had been evaluated by Dr. Vaught for bilateral carpal tunnel syndrome. He said that his job required turning keys, placing handcuffs on prisoners, typing and writing "quite a bit" and that his hands were getting more severe. He said that when he underwent the cervical MRI (due to his history of neck pain and prior disc bulges), in addition to the findings described previously, there was an increased bone marrow signal seen. The doctor noted that Petitioner had undergone surgery for a malignant brain tumor in 1993, that he suffered from morbid obesity and that he took testosterone injections. Examination on this date revealed that he was 6"1' tall and weighed 390 pounds. The doctor reviewed the MRI and thought that it did show T-1 signal changes in the bone marrow. A test run by the doctor that date revealed an overabundance of normocytic red blood cells. Other blood work was done that date. The doctor thought that the changes in the blood marrow were due to Petitioner's polycythemic state (an increase in the overall volume of red blood cells in the blood). He thought that could be due to his chronic lack of oxygen from his obstructive sleep apnea due to his morbid obesity, chronic tobacco abuse and his testosterone supplementation. Petitioner was advised to lose weight, stop smoking, use a CPAP machine and monitor his testosterone levels. He did believe that he was okay to undergo surgery. (RX 5)

On April 14, 2014 Petitioner returned to Dr. Vaught. It was noted that his family physician was Dr. Lisa Lowry. He still had persistent right hand aching and numbness. The doctor said the neurodiagnostic studies from February 2014 revealed moderate to severe right median nerve entrapment at the wrist. He had mild right-sided grip weakness and mild dexterity issues of the right hand. The symptoms were primarily at night, but they were now occurring throughout the day with repetitive hand movement. He rated his pain level at 5/10. On this date, he was taking Cyanocobalamin (used for treatment of lack of vitamin B-12), testosterone, Trazadone (a tetracyclic anti-depressant), Sertraline (another anti-antidepressant also used for anxiety), Montelukast sodium (a medication used for the treatment of asthma and allergies), Naproxen (anti-inflammatory agent), Liothyronine sodium (a medication to

treat hypothyroidism), Levothyroxine sodium (another medication used to treat hypothyroidism), and Vitamin D. He was taking both hypothyroid medications daily. He was taking 5 micrograms of the Liothyronine and an unknown amount of the Levothyroxine. Examination of the upper extremities revealed that the power testing was normal. Sensory examination revealed decreased sensation in the median nerve distribution on the right and on the left. The rest of the examination was normal. The doctor's diagnoses included bilateral carpal tunnel syndrome, cervicalgia, numbness and paresthesia and cervical spondylosis. The doctor thought that Petitioner was suffering from a "double crush syndrome". Petitioner wanted to undergo surgery on the right hand for the carpal tunnel syndrome. The doctor said that Petitioner would need cervical spine surgery if his issues persisted. (PX 1)

Petitioner followed up with Dr. Lowry-Rohlfing on May 20, 2014 for complaints of lightheadedness when turning his neck. His medications included Zithromax, Vistaril, Zoloft, Voltaren, Desyrel, and Astepro. He reported experiencing vertigo when turning his neck. This had been occurring occasionally for two weeks. He was diagnosed with labyrinthitis and prescribed antibiotics and vertigo medication. (PX 2, RX3)

On June 23, 2014 Petitioner followed up with Dr. Moore, the cancer specialist. It was noted that since his diagnosis of polycythemia he had stopped his testosterone supplementation and was using the CPAP nightly. He said he had been trying to cut back on his smoking. He had not gained much weight since the last appointment. He was 6'1" tall and weighed 398.3 pounds. His BMI was 51.5. Lab work was performed and it revealed a white blood cell count of 9.2, hemoglobin of 16.5, Hematocrit at 49.3 and platelets of 237,000. The doctor concluded that his hemoglobin and Hematocrit counts had returned to within normal limits. Diagnosis remained the same. He said that this was once again a combination of various medical conditions as outlined before. Petitioner's weight had increased. The doctor told him to continue with the CPAP therapy, lose weight and stop smoking. He also noted that the MRI of Petitioner's cervical spine, showing increased bone marrow signaling, was concerning for a possible underling hematologic disorder. (RX 5, 6)

On August 25, 2014 Dr. Vaught prepared a letter to Petitioner's attorney stating that he reviewed job descriptions for a dispatcher and a correctional officer and that, in his opinion, those job activities could have led to the development of his carpal tunnel syndrome. He also said that it could have aggravated a pre-existing condition. According to the job descriptions, a dispatcher typed for 6 hours a day, wrote for two hours a day, answered the phone for one hour and used a computer mouse six hours a day. A corrections officer locked and unlocked doors 30 to 50 times a shift, typed for 3 hours, used a mouse for one hour, wrote for two hours, opened and closed pill bottled 5

– 10 minutes, and handcuffed people 5 – 10 times a day. Occasionally, they cooked and mopped for about one hour each and cleaned for thirty minutes. He made no comment with regard to the cervical spine issues and its potential relationship to Petitioner's work activities. He did not address Petitioner's elbows. (PX 1, dep. ex. B,C)

On October 27, 2014, Petitioner was seen by his family physician, Dr. Lisa Lowry-Rohlfing. He was following up for refills on his prescription medications and questions about lab work. He denied any other concerns. His medications included Desyrel, Zoloft, and Voltaren. His past medical history included hypothyroidism, hypertension, seizures, and a mood disorder. His past surgical history included treatment for right carpal tunnel syndrome. It was noted he smoked two packs of cigarettes per day. He had previously been on a high dose of testosterone which caused a significant increase in his red blood cells. He was given a prescription of Astepro and Mucinex. There was no mention of pain, numbness or tingling in Petitioner's hands. (PX 2, RX 3)

On December 22, 2014, Petitioner followed up with Dr. Andrew Moore for his secondary polycythemia and exogenous testosterone supplementation. (RX 5, RX 6)

On February 18, 2015, Petitioner was seen at Chester Clinic for a depo-testosterone injection. (PX 2)

Dr. Vaught was deposed on February 5, 2015. (PX 15) Dr. Vaught, certified in neurosurgery and IMEs, testified that he was generally aware of Petitioner's job duties. He testified that he was aware Petitioner used a keyboard, wrote by hand, used a telephone, and used keys for the jail. (PX1, p. 10). Dr. Vaught also testified that he reviewed a job description that was apparently prepared by Petitioner and provided to Dr. Vaught by Petitioner's attorney. (See PX1, p. 12-13). Dr. Vaught testified on direct examination that Petitioner's job duties could have contributed to his development of bilateral carpal tunnel syndrome and/or aggravated any preexisting carpal tunnel syndrome. (*Id.* 11).

Dr. Vaught testified that Petitioner told him bracing helped his hand/wrist while at work. (*Id.* 7)

The job description, attached to the deposition transcript as an exhibit, noted job duties for a dispatcher and correctional officer. (*Id.* deposition exhibit C). The dispatch job duties represent that Petitioner typed 6 hours a day, wrote 2 hours a day, answered phones for 1 hour a day, and used a computer mouse 6 hours a day. The correctional officer job description represented that Petitioner locked and unlocked doors 30-50 times a day, typed 3 hours a day, used a computer mouse 1 hour a day, wrote 2 hours a day, occasionally cooked 1 hour a day, occasionally mopped 1 hour a day, opened and closed pill bottles 5 to 10 minutes a day, occasionally cleaned 30 minutes a day, and handcuffed inmates 5 to 10 times a day.

On cross-examination Dr. Vaught admitted that his causation opinion was based upon the assumption that he was provided with an accurate description of Petitioner's job duties. (*Id.* at 20). He admitted that he did not conduct an "exhaustive investigation" of Petitioner's job duties and took the job description as provided to him as representative of the duties Petitioner performed on a daily basis. He admitted that the job duties listed for a correctional officer would more likely cause carpal tunnel syndrome than those listed on the dispatch job duties. (*Id.* at 23). He also admitted that locking and unlocking doors 30 to 50 times daily (or 3 to 6 times an hour) would not be a highly repetitive activity classically associated with an activity that would cause carpal tunnel syndrome. (*Id.* at 22). Dr. Vaught also admitted that Petitioner was at risk for developing carpal tunnel syndrome because of his morbid obesity, hypothyroidism, smoking habit, and elevated blood sugar levels. (*Id.* at 24).

Dr. Vaught admitted that the cervical pathology evidenced on the March 2014 MRI could cause or contribute to the development of radiculopathy. He further stated that the numbness and tingling a patient experiences with the pathologies noted on the MRI could mimic the numbness and tingling associated with carpal tunnel syndrome. (*Id.* at 26).

On February 18, 2015 Petitioner underwent another testosterone injection. (RX 3)

On April 22, 2015 Petitioner was re-examined by Dr. German at the request of Respondent and a report followed. (RX 9, dep. ex. 3) Petitioner provided a history of his job duties as both a correctional officer and a dispatcher for Randolph County and they also reviewed two job descriptions together. Dr. German reviewed additional medical records received since Petitioner was last evaluated by him. He obtained a history from Petitioner regarding his work duties as a correctional officer. He noted that Petitioner would check out keys, a radio and other equipment for his shift. Cell counts would be taken twice a shift along with visual checks of any inmates on suicide watch every 15 minutes and general population every 20-30 minutes. On average, 2 new inmates were booked per shift. He would provide evening and bedtime prescription medications and dinner would be pass through chuckholes approximately 16 times per day. Lock down occurred at 9:00 PM nightly. Petitioner may also mop floors, clean bathrooms and replace paper products. Trash was taken to dumpsters. Petitioner would use keys to open locks about 30-50 times per shift. Regarding his activities as a dispatcher, his job duties were primarily computer and phone based. Petitioner described the symptoms in his hands as being stable since his initial visit in October of 2012. Petitioner described numbness and tingling mainly involved the entire hand but would sometimes only the thumb, index and long fingers. He noted there might be radiation to the elbow and that his symptoms were greater on the right than left. No neck pain was noted. On physical examination, Petitioner had negative Tinel's sign, Phalen's sign and median nerve

compression sing bilaterally. There was no tenderness over the ulnar nerves at the elbow bilaterally. His strength was excellent. Dr. German's diagnosis remained unchanged from his initial evaluation with numbness and tingling in both hands of unknown etiology. He had stable symptoms since his initial evaluation and probable carpal tunnel syndrome. He also noted cervical spine disease with double crush syndrome. He noted that the Petitioner has several risk factors for the development of carpal tunnel syndrome including his weight, smoking, and history of hypothyroidism. Dr. German noted that carpal tunnel syndrome can cause by numerous etiologies but in order for work activities to contribute to that cause, there must be significant repetition with force and/or pressure over a lengthy period of time. He opined that turning a key and opening a chuck door on average of every 7-10 minutes cannot be considered repetitious even with the possibility of significant pressure or force. He opined Petitioner was in need of further work up for his carpal tunnel syndrome, including a repeat nerve conduction study due to his negative physical exam findings.

Dr. German was deposed on June 17, 2015. (RX 9) Dr. German, a board certified plastic surgeon with an added qualification in hand surgery, testified consistent with his earlier reports. He further testified that he and Petitioner reviewed two job descriptions together; the job description Petitioner apparently prepared and a job description prepared by Respondent and discussed his job activities. (RX9, p. 16). With respect to Petitioner's job duties as a correctional officer, Dr. German testified Petitioner told him he checked out keys, a radio, and other equipment for the shift. He performed cell counts twice a shift and visual check of inmates on suicide watch every 15 minutes. He looked into the general population every 20 to 30 minutes. Two new inmates may be booked every shift. He would also give prescription medicines and pass out dinner trays through chuckholes. He may occasional mop floors, clean bathrooms, or replace paper products. He would use keys to open door locks 30 to 50 times a shift, or 4 to 6 times an hour and open chuckholes approximately 16 times per day (RX9, p. 16-17, and depo exhibit 3). With respect to Petitioner's job activities as a dispatcher, Dr. German noted Petitioner primarily performed computer based work with some typing and writing. According to Dr. German, Petitioner took approximately 20-25 calls a shift, or approximately three calls an hour. (RX9, deposition exhibit 2).

Dr. German diagnosed Petitioner with an element of double crush syndrome and possible early carpal tunnel syndrome. He did not believe Petitioner's hand symptoms were related to his job activities because the element of repetition, force, and pressure was not sufficient to develop carpal tunnel syndrome or even aggravate it. (RX9, pp. 18, 30). He also noted Petitioner was at a significant risk of developing carpal tunnel syndrome because of his morbid obesity, hypothyroidism, and elevated blood sugar. (*Id.* at 12).

On cross-examination Dr. German acknowledged a job description was provided by both parties. He was unaware of how much pressure or force Petitioner used, what type of keys Petitioner used, or the weight/condition of the jail doors. He did not personally review the MRI. He agreed Petitioner had several comorbid factors that would predispose him to develop a repetitive stress disorder. While Petitioner had evidence of carpal tunnel syndrome based upon his electrical studies, Dr. German did not feel the condition was presented based upon Petitioner's physical exam. (RX 9)

Petitioner's case proceeded to arbitration on September 10, 2015. Sheriff Shannon Wolff was in attendance as Respondent's representative.

Petitioner testified that heworked as a correctional officer from January of 2012 through January of 2015. He testified he worked 8-hour shifts as a correctional officer, for a weekly total of 40 hours. With respect to his alleged work duties as a correctional officer, he testified he would unlock and open cell doors, open and close chuckholes to serve meals, pass out medications to inmates, sweep floors, and cuff and uncuff inmates as they came into the facility to be booked. If there was no "trustee" they would mop the floors, cook meals, and do the dishes. On direct examination he testified the chuckholes weighed between 2 and 5 pounds and he would open and close those chuckholes between 10 and 20 times per shift, at a minimum. He further testified he would spend 30 to 45 minutes per day opening and closing 100 lb. cell doors, 30 minutes sweeping (when necessary), 5 to 15 minutes opening chuckholes, and 5 to 30 minutes passing out medications (a process he described in detail). On cross examination Petitioner admitted he would use keys to open and unlock doors 30 to 50 times per shift.

Petitioner worked as a telecommunicator from May 2009 through December 2011. With respect to his alleged work duties as a telecommunicator, he testified that he would answer non-emergency and emergency phone calls, type entries into a computer system, handwrite forms, and take notes by hand. On direct examination he testified he worked 8-hour shifts for a total of 40 hours per week. He further testified that those daily 8-hour shifts were comprised of 6 hours of typing, 6 hours of computer mouse use, and 3 to 4 hours of writing. On cross-examination, Petitioner admitted that he did not actually type for 6 hours, did not actually scroll around the computer with a mouse for 6 hours or fill out forms by hand for 2 to 3 hours. He admitted that his computer use and handwriting were intermittent and that he would only type off and on during a 6-hour period.

Petitioner testified he was working for Respondent as a correctional officer on September 5, 2012 and he noticed continual numbness in both hands. He further testified about being treated for neck problems before September 5, 2012 and undergoing an MRI and physical therapy. Petitioner testified that those symptoms

"kind of resolved." Despite the treatment for his neck his numbness and tingling continued. Petitioner further testified that by September 5, 2012 Petitioner's pain was worse and his doctor told him he had carpal tunnel syndrome and needed treatment. Petitioner desires to undergo surgery.

On cross-examination Petitioner was asked about other medical conditions he had and various medications he had taken over time. Petitioner agreed that Dr. Lowry-Rohlfing diagnosed him with carpal tunnel syndrome "around" September 5, 2012. He also acknowledged that his accident report only referred to right hand pain with typing and writing.

Petitioner further explained that he worked pat-time for Respondent as a telecommunicator in1997-1998 and became full-time in 2009. He also worked full-time for the Sparta Police Department and as an office for a "local department." He also did state police dispatching for approximately 3 – 3 ½ years ending in August of 2005. While working for Respondent Petitioner has also worked as an officer and part-time deputy for the Evansville Police Department (approximately ten hours a week). Petitioner acknowledged being truthful with Dr. German and reviewing his job duties with him.

Petitioner also acknowledged that his carpal tunnel syndrome symptoms began after he started riding a motorcycle.

Petitioner testified that his braces never really helped.

The Arbitrator concludes:

1. **Issues C and F, "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent" and "Is Petitioner's current condition of ill-being causally related to the injury?":**

Petitioner failed to prove he sustained an accident on September 5, 2012 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being in his right and left wrists and right and left elbows is causally related to that accident or his employment with Respondent.

Petitioner bears the burden of proof on the issues of accident and causal connection. In addressing these issues and concluding that Petitioner failed to meet his burden of proof the Arbitrator has focused on the chronological medical records, the opinions of the parties' experts, and Petitioner's testimony.

When Petitioner reported his alleged injuries on September 6, 2012 he attributed them to his job duties of typing and writing while working as a dispatcher, a job he had last performed in December of 2011, approximately 9 – 10 months earlier. Of some

concern to this Arbitrator is that the reporting of the alleged injury came just a few days before Petitioner signed his Application for Adjustment of Claim. Up until that time Petitioner was being seen (2011 and early 2012) by a chiropractor and his primary care physician for global complaints, including his neck, shoulders, upper back and right arm. He was also going through some personal stressful issues. Petitioner's medical records from December 10, 2009 through June 28, 2011 contain very few references to upper extremity complaints allegedly due to work duties. The Arbitrator does acknowledge references in March of 2011 to right-sided hand pain that Petitioner related to his work station. However, in June of 2011 no further complaints were noted and while Petitioner reported trying to change jobs at work to improve his level of "stress" that, given the totality of the medical records and lack of explanatory testimony, could be interpreted in a variety of ways and not necessarily repetitive "stress." Then, in August of 2011, he tells yet another doctor that his right-sided complaints began after riding a motorcycle and were reportedly increased by "computer work." It was not until Petitioner reported his accident that he began giving a consistent history of allegedly work-related problems in his right hand/wrist and even thereafter, he switched the history to include not only work as a dispatcher but also as a corrections officer. The inconsistent history regarding the history of Petitioner's complaints is very troubling.

Additionally, none of the foregoing medical history was considered by Dr. Vaught in rendering his causation opinion. Dr. Vaught did not review any prior treatment records. Petitioner did not share these histories with the doctor. Furthermore, when initially seen by Dr. Vaught Petitioner did not attribute his bilateral hand and right elbow symptoms to his work as a telecommunicator. Dr. Vaught's office note only references duties as a corrections officer. It was only in anticipation of a hearing/trial that Dr. Vaught was given a generic job description for both positions upon which he rendered his opinion. Having reviewed the doctor's notes and testimony this Arbitrator is not persuaded that Dr. Vaught had a thorough and complete understanding of Petitioner's jobs and/or his medical history. Dr. Vaught further based his causation opinion on the length of time Petitioner had performed those jobs (PX 1, p. 13). While the job description arguably set forth how much time per day was spent in various activities, Dr. Vaught's notes and testimony are devoid of any information as to how long Petitioner had worked as a dispatcher and a corrections officer. Dr. Vaught also acknowledged on cross-examination that he, essentially, had very little, if any, specific information as to the details of petitioner's job tasks such as whether computer usage was continuous or intermittent over a six hour period.

In contrast, Dr. German's opinions were based upon more information that those of Dr. Vaught. While he initially lacked some information, that information was subsequently provided to him and considered by him. He also discussed Petitioner's

job duties with Petitioner in greater detail than Dr. Vaught. The foregoing, combined with concessions made by Dr. Vaught during cross-examination, rendered Dr. German's opinions more persuasive than those of Dr. Vaught.

The Arbitrator also notes that Petitioner failed to provide little, if any, testimony/evidence as to how he used his left hand/wrist on a repetitive basis at work. Petitioner's left hand/wrist complaints were minimal to non-existent. He further failed to provide detailed testimony as to how his elbows were allegedly affected by his job duties. Finally, no doctor expressed an expert causation opinion regarding Petitioner's elbows.

2. **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?":**

Liability for medical bills is based upon the Arbitrator's determination of accident and causal connection. The Arbitrator, having previously found that Petitioner failed to prove accident or causal connection, denies Petitioner's request for payment of medical expenses.

3. **Issue K, "Is Petitioner entitled to prospective medical treatment?":**

Consistent with her determination of accident and causal connection, prospective medical care is denied.

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

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MELODY SPONGBERG,

Petitioner,

vs. NO: 04 WC 38447

ALSIP PARK DISTRICT,

Respondent,

16IWCC0396

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of "Denial of Motion to Reinstate Claim" and being advised of the facts and law, reverses the Denial of Reinstatement by the Arbitrator as stated below.

The Commission has reviewed the lengthy history of this case and notes that this is the third time it was dismissed. The first dismissal was due to an administrative error and it was reinstated. It was dismissed a second time on April 10, 2014, when Petitioner failed to appear. On August 7, 2014, Petitioner appeared for the hearing on her motion to reinstate. Petitioner testified that she did not want to accept Respondent's settlement offer and wished to proceed to trial. She testified that over the past couple of years she did miss some scheduled hearing dates due to the health issues of, and the ultimate passing of, her mother and subsequently some health issues with her father who she traveled out of state to assist. The Arbitrator granted the motion to reinstate but ordered Petitioner to appear for hearing on September 10 and 11, 2014. Petitioner complied with that instruction and was present on those dates but the hearing did not proceed for other reasons. The case was continued on other dates as well due to no fault of the Petitioner.

On Monday, May 11, 2015, Petitioner failed to appear for hearing on this matter. Petitioner's attorney informed the Arbitrator that Petitioner had called him late Friday to inform him that she was going to be out of town until Monday evening and would be unable to attend the hearing. Petitioner's attorney indicated that he told Petitioner that this would be a problem and that Respondent's attorney would likely ask for a dismissal. The Arbitrator granted the motion to dismiss.

16IWCC0396

Petitioner filed a timely motion to reinstate and a hearing was held on August 11, 2015, which Petitioner attended. Petitioner testified that she had traveled to Purdue University to help her 22-year-old adult son, who drives and had his own car at Purdue, move out of his apartment and move back to Alsip, Illinois, which is about an hour away. The Arbitrator found Petitioner's testimony incredulous and could not understand why Petitioner wouldn't have gone to Purdue on Sunday morning and returned later Sunday evening or early Monday morning knowing that she had a court date. Instead, Petitioner left Alsip, Illinois on Sunday afternoon, stayed overnight, finished packing on Monday, and drove home Monday afternoon, missing her trial hearing. The Arbitrator denied Petitioner's motion to reinstate. Petitioner filed a timely Petition for Review on August 13, 2015.

The Commission agrees with the Arbitrator that going to Purdue is not a reasonable excuse for missing the hearing on May 11, 2015, and we are by no means minimizing the seriousness of her absence. It showed a lack of diligence in pursuing her claim and was disrespectful. However, we review this dismissal in light of the entire history of the case. We are not saying that all of Petitioner's prior absences are reasonable but, on multiple occasions, Petitioner's failure to appear was due to the more understandable reason that she was attending to health emergencies involving her parents. On other occasions, Petitioner did appear and was ready for trial but the case was continued for reasons that were not Petitioner's fault. The Commission notes that Petitioner has attended each of the hearings on her motions to reinstate and was present and ready for trial on September 10 and 11, 2014, as instructed by the Arbitrator. Upon careful consideration of all of the circumstances, we find that Petitioner should be given a final opportunity to vigorously pursue her claim and receive a hearing on the merits of her case. We strongly admonish Petitioner to attend all scheduled hearing dates in this matter.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's denial of reinstatement is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

DATED: JUN 14 2016

Charles J. DeVriendt

Ruth W. White

Michael J. Brennan

SE/
O: 4/27/16
49

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carlos Garcia,
Petitioner,

vs. No. 13 WC 34033

Tenacious Cleaning Services,
Respondent.

16IWCC0397

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, temporary disability and penalties and attorney's 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).*

Petitioner Carlos Garcia, a 34 year old maintenance worker, testified that on 8/23/13 while applying stripper to a floor he slipped and fell onto his knees and hands, injuring his back. He worked with Israel Guarneros, who testified Petitioner fell as alleged. Petitioner also worked with Cutberto Sotelo and Alma Valencia, both of whom testified that he slipped and lost his balance, but did not fall onto his knees or hands.

Petitioner did not have bothersome pain until the next day and did not seek treatment until 9/3/13, when he went to La Clinica complaining of low back pain. Following treatment consisting of x-rays, physical therapy and injections, Petitioner was referred to Dr. Geoffrey Dixon, M.D. and Dr. Kevin Koutsky, M.D., both of whom recommended spine surgery. Petitioner desires to undergo this surgery.

16IWCC0397

Records which Petitioner offered into evidence included a 9/4/13 MRI report showing bulging discs at L4-5 and L5-S1 with grade II spondylolisthesis, and a 9/24/13 NCV/EMG report showing evidence of right L5 radiculopathy. Dr. Dixon's 4/17/14 report included his recommendation for an L5-S1 laminectomy with L5-S1 interbody fusion/instrumentation. Dr. Christopher Morgan, M.D. opined on 1/14/14 that Petitioner's work injury made his prior condition symptomatic. On 8/6/14 Dr. Koutsky reported that Petitioner was a reasonable candidate for a decompression and stabilization with instrumentation.

Respondent offered into evidence the opinions of its Section 12 doctor, Daniel Troy, M.D. On 5/29/14, Dr. Troy agreed that Petitioner's symptoms were related to his work incident and that Petitioner was a candidate for an L4-S1 fusion with hardware. On 9/18/14, Dr. Troy wrote an addendum report in which he opined that ***if*** Petitioner's accident did not involve him falling to the floor on his hands and knees, and if Petitioner had only slipped and caught himself, then that would not have been a strong enough mechanism of injury to aggravate his preexisting degenerative condition.

While the Commission notes that Petitioner has some credibility issues, including his giving differing versions of how he slipped and/or fell on 8/23/13, the Commission nonetheless finds that Petitioner presented sufficient evidence to support and corroborate his testimony of falling onto at least his hands, if not also his knees. Witness Guarneros' testimony supported this history, and Dr. Troy reported Petitioner told him he had fallen onto his hands. Petitioner testified he had to switch gloves after his fall because the stripping fluid had gotten on them. No witnesses testified he had not done this. The Commission therefore finds that Petitioner has proven his current condition of ill-being is causally related to his 8/23/13 work accident.

Although Petitioner testified he has not worked since 9/3/13, that is contradicted by his treater's medical records. The La Clinica notes dated 2/21/14 and 2/28/14 both report that Petitioner, "was working at a new job." (PX1, p. 113). Shortly before that, on 12/10/13, Petitioner reported his symptoms had improved. His treaters at La Clinica found him able to return to modified work duties on 12/30/13, 1/9/14 and 1/28/14. On 5/29/14 Dr. Troy reported Petitioner had been working light duty from 3/23/13 through approximately 8/30/13. Five urine drug screens of Petitioner taken between 9/10/13 and 4/22/14 reveal he had not been taking prescription pain relievers prescribed to him during that period. The Commission does not find Petitioner's testimony credible that he did not, and was not able to, work since the date of his accident. Petitioner has not proven he was entitled to TTD after 2/20/14, the day before his treating medical records first show him to be working at a new job.

The Commission accepts the opinions of Petitioner's treating doctors that he is a candidate for lumbar spine surgery, and that his treatment to date was reasonable and necessary. Respondent's IME doctor, Dr. Troy, concurred with these opinions in his 5/29/14 report. The Commission finds Petitioner's treatment to date, and need for lumbar spine surgery, to be causally related to his work injury. Dr. Troy's alternate opinion of 9/18/14 – that if Petitioner only slipped and regained his balance without touching the floor, then Petitioner's condition would not be causally related – is moot, given the Commission's finding that Petitioner fell onto his hands.

16IWCC0397

As Respondent notes in its brief, Petitioner presented no medical records corresponding to the treatment reflected on the following medical bills offered into evidence:

Date of Service:	Provider:	Page No.:
09/10/13	Dr. Neeraj Jain	PX4, p. 202
09/16/13	Dr. Neeraj Jain	PX4, p. 202
12/17/13	Dr. Neeraj Jain	PX4, p. 216
01/03/14	Dr. Eugene Jao	PX4, p. 221
01/07/14	Dr. Neeraj Jain	PX4, p. 223
01/17/14	Dr. Eugene Jao	PX4, p. 226
02/13/14	Dr. Neeraj Jain	PX4, p. 234
05/05/14	Dr. Eugene Jao	PX4, p. 255
12/18/14	Dr. Neeraj Jain	PX4, p. 266
03/10/14	Dr. Neeraj Jain	PX4, p. 267-268
05/09/14	Dr. Neeraj Jain	PX4, p. 269-270
05/12/14	Dr. Neeraj Jain	PX4, p. 271-272
12/18/13	APM	PX4, p. 273
12/02/13	APM	PX4, p. 274
12/18/13	APM	PX4, p. 275
03/10/14	APM	PX4, p. 276
03/10/14	APM	PX4, p. 277
12/12/13	Dr. Geoffrey Dixon	PX4, p. 279-280
12/18/13	Dr. Aleksander Goldvekht	PX4, p. 281
03/10/14	Dr. Aleksander Goldvekht	PX4, p. 282
05/09/14	Dr. Aleksander Goldvekht	PX4, p. 283
05/12/14	Dr. Neeraj Jain	PX4, p. 284
12/19/13	Argus Medical	PX4, p. 285
12/26/13	Argus Medical	PX4, p. 286
01/03/14	Argus Medical	PX4, p. 287

The Commission therefore finds Petitioner failed to prove entitlement to the above itemized bills, and modifies the Arbitrator's award of medical by denying these bills. The Arbitrator's award of all other medical bills, pursuant to the fee schedule, is affirmed. Given the medical opinions concurring that Petitioner is a candidate for lumbar spine surgery, the Commission affirms and adopts the Arbitrator's award of prospective medical care, including lumbar spine surgery.

The Commission reverses the Arbitrator's award of penalties and attorney's fees under §16, §19(k) and §19(l) of the Act, and finds that there was sufficient evidence in the record to show that Respondent investigated this claim, and that its defense was not, "objectively vexatious and unreasonable." Respondent relied on not only one but two witnesses who gave testimony contrary to Petitioner's. Respondent also relied upon the conclusions and opinions of its own medical expert and treating physician, Dr. Zaragoza, who initially diagnosed Petitioner's injury as only a lumbosacral strain. Respondent did accept that claim, and paid benefits it reasonably believed were related to that injury. Dr. Troy's 9/18/14 alternate opinion was based upon a set of facts which Respondent reasonably believed it could prove at trial. That opinion

was not a reversal of Dr. Troy's earlier opinions, for which he assumed facts provided him by Petitioner.

Respondent's reliance on utilization review reports non-certifying certain treatment, including Petitioner's initial MRI scan, was not flawed or unreasonable. The utilization review doctor set forth his reasons for non-certifying the treatment Petitioner sought (see RX6, p. 22). No appeals of any non-certifications were made, and Petitioner offered no evidence to dispute the accuracy of the bases cited by the UR reviewer. The fact that Respondent may have produced copies of the UR reports to Petitioner as potential trial exhibits two days before trial, is not evidence that Petitioner only then first learned of them. Petitioner presented no testimony or evidence that he or his attorney had not received copies of the subject UR reports long before, around the date(s) they were prepared, as typically is the case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 2, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and that Respondent pay to Petitioner the sum of $311.25 per week, commencing on September 3, 2013 through February 20, 2014, totaling 24-3/7 weeks, that being the period of Petitioner's temporary total incapacity from work under §8(b) and §19(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical expenses Respondent is to pay is modified. Respondent shall pay as provided in §8(a) of the Act, and pursuant to the fee schedule, only those reasonable and necessary medical expenses of Petitioner that were awarded by the Arbitrator, ***except for*** those bills itemized in this Decision above, which are denied due to lack of corresponding treatment records.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of Penalties and Attorney's Fees pursuant to §16, §19(k) and §19(l) of the Act is reversed. No penalties or attorney's fees are awarded to Petitioner.

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.

16IWCC0397

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,000.00. 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.

JUN 14 2016

DATED:

o-04/27/16
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

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

GARCIA, CARLOS
Employee/Petitioner

Case# **13WC034033**

16IWCC0397

TENACIOUS CLEANING SERVICES
Employer/Respondent

On 3/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% 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:

1427 BERG & BERG
STEPHEN M WAUCK
2100 W 35TH ST
CHICAGO, IL 60609

1120 BRADY CONNOLLY & MASUDA PC
JASON R STETZ
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Carlos Garcia
Employee/Petitioner

v.

Tenacious Cleaning Services
Employer/Respondent

Case # **13** WC **34033**

Consolidated cases: **N/A**

16IWCC0397

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **October 15, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **August 23, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**[no stipulation]**; the average weekly wage was $**466.87**.

On the date of accident, Petitioner was **34** 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 $**4,637.02** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**9,611.97** for other benefits, for a total credit of $**14,248.99**.

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

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $311.25/week for 58 and 2/7 weeks, commencing September 3, 2013, through October 15, 2014, as provided in Section 8(b) of the Act.

Medical Benefits
Respondent shall pay reasonable and necessary medical services of $43,885.07, as provided in Sections 8(a) and 8.2 of the Act.

Prospective Medical Care
Respondent shall authorize and pay for a lumbar spinal fusion with instrumentation, as recommended by Petitioner's treating physicians and by Respondent's IME physician.

Penalties
Respondent shall pay to Petitioner penalties of $11,477.89, as provided in Section 16 of the Act; $28,694.74, as provided in Section 19(k) of the Act; and $10,000.00, as provided in Section 19(l) of the Act.

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

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

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

16IWCC0397

Signature of Arbitrator

3/2/15
Date

ICArbDec19(b)

MAR 2 - 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CARLOS GARCIA, Petitioner/Employee,	)	
v.	)	13 WC 34033
TENACIOUS CLEANING SERVICES, Respondent/Employer.	)	Chicago Arbitrator Hegarty

16IWCC0397

ADDENDUM TO ARBITRATION DECISION

This matter proceeded to hearing before Arbitrator Jessica A. Hegarty on October 15, 2014, in Chicago, Illinois.

The disputed issues in this case are:

(1) Causal connection;
(2) Medical expenses;
(3) Temporary total disability benefits ("TTD");
(4) Prospective medical treatment; and
(5) Attorney's fees and penalties.

Respondent stipulated that on August 23, 2013, Petitioner sustained an accident that arose out of and in the course of his employment but dispute Petitioner's description of the accident.

FINDINGS OF FACT

It is undisputed that on August 23, 2013, Petitioner Carlos Garcia was employed by Tenacious Cleaning Services as part of a maintenance crew at Catherine Cook School in Chicago, Illinois (ARB 1; TX. pp. 9, 10).

Petitioner's duties on the accident date involved applying a stripper to the floor to remove old wax followed by the application of a new coat of wax. The stripper was first poured into a bucket and then applied to the floor using a mop. Petitioner would typically work in a three-person team in which his job was to apply the stripper with a mop.

On August 23, 2013, Petitioner was working with co-workers Israel Guarneros and Cutberto Sotelo. (TX. pp. 11, 12) Petitioner testified that as he was applying stripper to the floor, he was unaware that another team had already applied stripper to the area immediately behind the area in which he was working. (TX, p. 13) According to Petitioner, as he stepped onto the area

behind him, he lost his balance and fell onto the floor, landing on his hands and knees. (TX, p. 13, 20)

Petitioner testified that three people were present when he fell: Israel Guarneros was seven to ten feet away while Cutberto Sotelo and Alma Valencia were both about twenty feet away. (TX, pp. 14, 19-20)

Petitioner called Israel Guarneros (testimony discussed at length below) who testified he was standing five to six feet away from Petitioner when Petitioner fell. (TX, p. 30) Mr. Guarneros further testified that as Petitioner was walking to retrieve a cleaning supply, he lost his balance on the slippery floor and fell onto the floor landing on his hands on knees. (Id.) Mr. Guarneros testified Petitioner had fluid on his hands and his knees after the fall and proceeded to clean himself off with a rag. (TX, p. 33)

Respondent called two witnesses (also discussed in greater detail below) as to the mechanism of injury: Alma Valencia and Cutberto Sotelo. Ms. Valencia testified that she was two to five feet away from Petitioner when he lost his balance. Ms. Valencia testified that Petitioner did lose his balance but did not fall to the floor. (TX, p. 43) According to Ms. Valencia, she told Petitioner to "be careful" after he lost his balance (TX, p. 44). Respondent's second witness, Mr. Sotelo, testified that he was working two to three feet away from Petitioner, when he slipped and "lost control" but did not fall to the floor (TX, p. 54).

Petitioner testified that he began experiencing low back pain the day after the accident that increased over the course of the next week. (TX, p. 14) Petitioner testified that he continued working for about a week following the accident. (TX, pp. 23, 24)

Petitioner testified that on August, 29, 2013, he reported that he was experiencing pain from the accident to Alma Valencia. (TX, p. 24)

Medical Treatment

On September 3, 2013, Petitioner presented to La Clinica where he filled out paperwork, reflecting pain complaints in his lower right back ranging from 7/10 to a 9/10. (PX1, p. 1) Adrian Zaragoza, DC, noted it was Petitioner's initial examination for a "work-related injury" sustained on August 23, 2013. (PX1, p. 3) X-rays were taken and Petitioner was placed off-work for two weeks. (PX1, p. 2-3)

On September 4, 2013, Petitioner underwent a lumbar MRI. The impressions noted on the MRI report were:

1. Disc bulging at L4-L5 and L5-S1.
2. Spondylolisthesis grade II in nature with discal uncovering and Modic change adjacent endplate at L5-S1. (PX1, p. 6)

On September 6, 2013, Dr. Vasquez of La Clinica noted that Petitioner "continues to have severe low back pain but denies radiation down either extremity. He mentions that his pain starts in his

low back and travels forward to the right hip." (PX1, p. 7). The doctor noted "moderately severe tenderness at [Petitioner's] lumbar region". (Id.) The doctor reviewed and discussed the MRI report with Petitioner and recommended that Petitioner consult with a pain management doctor. (PX1, p. 9)

On September 11, 2013, Dr. Vazquez noted Petitioner's complaints of "lower back pain that radiates to his left hip". (PX1, p. 14) Dr. Vazquez noted that after the work accident Petitioner initially "dismissed his discomfort as something that would get better on its own and continued with his work duties. His pain progressively worsened during the upcoming days. The patient reported the accident on 8/30/13, which was not the date of injury, because it was the next time that he worked at the school with his supervisor". (PX1, p. 15)

On September 17, 2013, Dr. Zaragoza at La Clinica noted Petitioner's reports of back pain that varied from a 3 to a 9/10. The doctor further noted that Petitioner was "having a difficult time doing his ADLs such as sweeping, mopping, lifting or carrying his groceries". (PX1, p. 16) Dr. Zaragoza stated that as of September 18, 2013, Petitioner could return to "limited duties" with "no lifting/carrying greater than 5 lbs." and "no bending/squatting," and "office work only". (PX1, p. 18)

On September 17, 2013, records from Specialized Radiology Consultants reported lumbar X-rays indicating "spondylolytic spondylolisthesis Grade I, L5 on S1". (PX1, p. 5)

On September 18, 2013, Petitioner returned to La Clinica, stating "that he did not return to work because he was told that there was no light duty work at his job". (PX1, p. 21) Petitioner rated his low back pain "at a 4/10". Petitioner denied any pain radiating to his legs, but did mention "weakness in his legs after a long period of inactivity, i.e.: upon waking up in the morning". (PX1, p. 21)

On September 24, 2013, Petitioner underwent an EMG/NCV. The impression was of "right L5 radiculopathy". (PX1, p. 24) The report noted that Petitioner's history included "limited ROM in the L/S with pain in all ranges" (PX1, p. 24).

On October 15, 2013, Petitioner saw Dr. Jain who recommended a "bilateral L5-S1 transforaminal epidural steroid injection" and opined that Petitioner's "symptoms for which he is being seen today are directly related to the injury". (PX1, p. 36)

On October 17, 2013, Dr. Zaragoza placed Petitioner off of work. (PX1, p. 42)

As of November 12, 2013, Petitioner was still awaiting approval for lumbar injections. (PX1, p. 49)

On November 27, 2013, Dr. Zaragoza noted Petitioner's report that walking too much over the weekend "might have aggravated his low back discomfort". (PX1, p. 55). The doctor noted continued radiating pain symptoms. (PX1, p. 55)

On December 12, 2013, Dr. Zaragoza noted that Petitioner was to remain off-work until December 12, 2013, but could also return to work with 10 lb. restrictions. (PX1, p. 72) However, in the dictated treatment note from that day, he also wrote that Petitioner "will remain off work for 4 more weeks". (PX1, p. 69)

On December 30, 2013, La Clinica records note that Petitioner could return to "limited duties". The form did not indicate what Petitioner's specific restrictions were. (PX1, p. 78). The corresponding office note stated that "there is no light duty work available" for Petitioner. (PX1, p. 76)

On January 9, 2014, records from La Clinica note that Petitioner could return to limited duties with a 15 lb. lifting restriction, no bending or squatting. (PX1, p. 90)

As of January 28, 2014, Petitioner had still not received the lumbar facet joint injections that were previously recommended. (PX1, p. 95) Petitioner reported that his "pain now averages 8". (PX1, p. 95) Dr. Morgan recommended that Petitioner continue with his same modified duty work restrictions. (PX1, p. 95)

On February 6, 2014, La Clinica records note Petitioner's report that his employer did not have light duty employment available. (PX1, p. 107) He described his recovery as "slow" (PX1, p. 107). His "patient status form" from that day allowed him to return to light duty with a 10 lb. lifting restriction. (PX1, p. 109)

On March 6, 2014, Petitioner's "patient status form" reflects Petitioner was allowed to return to light duty with a 25 lb. lifting restriction, with no bending or squatting. (PX1, p. 117)

On March 14, 2014, La Clinica records note that Petitioner's low back pain was "strong" due to the injections he received. (PX1, p. 119).

On March 18 and March 20, 2014, La Clinica records noted that the lumbar injections did not improve Petitioner's pain (PX1, pp. 120, 122).

On April 17, 2014, Petitioner consulted with Dr. Geoffrey Dixon of Chicago Neurological Surgery. Dr. Dixon noted that the MRI "demonstrates degenerative disc disease with some broad based disk protrusion and lateral recess/foraminal stenosis at L5-S1 with a grade 2 spondylolisthesis and significant nerve root compression". (PX1, p. 132) Dr. Dixon recommended an L5-S1 laminectomy with L5-S1 interbody fusion and pedicle screw instrumentation. (Id) Dr. Dixon recommended Petitioner obtain a second opinion from Dr. Kevin Koutsky and ordered Petitioner to remain off work "pending completion of his treatment". (Id.)

On April 22, 2014, Petitioner was placed off-work by La Clinica. (PX1, p. 135)

On May 1, 2014, La Clinica records note Petitioner's report that he was "unable to perform exercises due to severe pain on lumbar spine". (PX1, p. 142) It was also noted that medication helped bring Petitioner's low back pain down from an 8/10 to a 4/10. (PX1, p. 143)

On May 20, 2014, La Clinica records note that Petitioner could only tolerate doing some of his exercises and stretches due to increased pain level when attempting to perform them. (PX1, p. 149)

On May 27, 2014, Dr. Jain noted that Petitioner did not feel "significant relief with the medial branch facet blocks". (PX1, p. 152) He instructed Petitioner to remain off work. (PX1, pp. 152, 154) However, two days later, Petitioner told Dr. Zaragoza at La Clinica that he wished to find a different job in some light duty capacity because he was "destitute for money". (PX1, p. 156) Dr. Zaragoza allowed him to work with a 15 lb. lifting restriction as of May 29, 2014. (PX1, p. 159)

Dr. Jain re-evaluated Petitioner on June 23, 2014, and told him to remain off work. (PX1, pp. 165, 167) Dr. Jain was concerned that Petitioner was developing a tolerance to his pain medication. (PX1, p. 165)

On August 6, 2014, Petitioner consulted with Dr. Koutsky who noted that Petitioner's MRI showed Grade 2 spondylolisthesis at L5-S1, with "some generalized protrusions" at L5-L5 and L5-S1, and "significant foraminal stenosis". The doctor noted that Petitioner's EMG showed evidence of right L5 radiculopathy consistent with his MRI pathology. (PX2, p. 185) Dr. Koutsky concluded that Petitioner had failed all conservative management, including medications, therapy, and injections. (PX2, p. 185) The doctor recommended surgery for Petitioner, noting that Petitioner "would be a reasonable candidate not only for a decompression but also stabilization with instrumentation due to his spondylolisthesis". (PX2, p. 185) Dr. Koutsky related the need for surgery to "a work-related aggravation of his grade 2 spondylolisthesis and stenosis". (PX2, p. 185) Dr. Koutsky noted a history of a slip-and-fall, but stated that Petitioner landed on his buttocks. (PX2, p. 184) Dr. Koutsky ordered Petitioner "off work for now". (PX2, p. 185).

On October 2, 2014, Petitioner was placed off work by Dr. Zaragoza pending a follow-up with Dr. Koutsky. (PX1, p. 182)

At trial, Petitioner testified that he would like to undergo the surgery recommended by his treating physicians. (TX, p. 16)

Petitioner also testified that he has not worked for Respondent since he began medical treatment at La Clinica on September 3, 2013. (TX, p. 17)

Israel Guarneros

Petitioner called Israel Guarneros who testified that he had worked for Respondent for about five years before Petitioner's accident. (TX, p. 27) At the time of the accident he was a supervisor in charge of the maintenance work done at Catherine Cook School and that is still employed by Respondent. (TX, p. 27, 38)

Mr. Guarneros testified that on the accident date he was working alongside Petitioner. (TX, p. 27) Mr. Guarneros was using a scrubbing machine while Petitioner applied stripper to the floor in order to remove the old wax. (TX, p. 28-28) At one point during their work, Mr. Guarneros instructed Petitioner to "go scrub the edges with a brush". (TX, p. 30) According to Mr. Guarneros, as Petitioner was walking to retrieve the brush, he lost his balance and slipped on the floor, landing on his hands and knees. Mr. Guarneros testified that Petitioner was unaware that stripper had been placed on the floor by another team of maintenance workers. (TX, p. 30) Mr. Guarneros testified that after he fell, Petitioner had fluid on his hands and his knees. Mr. Guarneros saw Petitioner clean himself with a rag after he fell. (TX, p. 33)

Mr. Guarneros testified that he was the closest person to Petitioner, standing "about five or six feet" away when the accident occurred. (TX, p. 30-31) Mr. Guarneros further testified that Alma Valencia also saw Petitioner fall, after which she laughed and said, "[B]e careful. Are you okay?" (TX, p. 34) Mr. Guarneros also testified that Cutberto Sotelo was a member of his team, but he was not sure whether Mr. Sotelo saw Petitioner fall. (TX, p. 35)

According to Mr. Guarneros, on one occasion a female supervisor asked him if "he had seen that Israel [sic] had fallen; and I told her yes". (TX, p. 38)

Mr. Guarneros recalled working full shifts a couple more times with Petitioner in the week following the accident and that during that period Petitioner was "complaining that something was hurting". (TX, p. 37) About a week after the accident, Petitioner asked Mr. Guarneros to take him to see a doctor as Petitioner does not drive. (TX, p. 36, 38) Mr. Guarneros testified that he met Petitioner working for Respondent and that they have "a friendship with work". (TX, p. 36)

Alma Valencia

Respondent's first witness was Alma Valencia. (TX, p. 39) Ms. Valencia has worked for Respondent for around 15 years and is currently employed by Respondent as an office manager. (TX, p. 40) Occasionally, when additional help is required at a jobsite, she will go to "supervise and take supplies". (TX, p. 41)

Ms. Valencia testified that on the alleged accident date, she was standing between two to five feet away from Petitioner when he lost his balance. According to Ms. Valencia Petitioner did not fall to the floor. (TX, p. 43) Ms. Valencia testified that she told Petitioner to "be careful". (TX, p. 44) She testified that other co-workers present at the time were Israel Guarneros and Cutberto Sotelo. (Id) According to Ms. Valencia, Petitioner finished his shift on August 23, 2013, and worked the next day (TX, p. 45). Petitioner worked again on August 30 and 31, 2013. (Id) Ms. Valencia testified that on August 30, 2013, Petitioner reported to her having had an accident on August 23, 2013, in which he fell on the floor. After Petitioner reported the accident, Ms. Valencia asserts that she told her boss, Bob Smith, about Petitioner's accident and gave Petitioner the "Workers' Comp information". (TX, p. 46) Ms. Valencia testified that she did not tell her boss that Petitioner did not fall.

Cutberto Sotelo

Respondent's second witness was Cutberto Sotelo (TX, p. 51). Mr. Sotelo has been employed by Respondent for about eleven (11) years and is currently a supervisor in charge of cleaning floors and the kitchen at Kendall College (TX, p. 52, 53).

Mr. Sotelo testified that on August 23, 2013, he was working with Petitioner, who was "using a bucket with a mop." (TX, p. 54) Mr. Sotelo recalled that Petitioner "slipped" and "lost control" but "did not fall to the floor". (TX, p. 54) Mr. Sotelo stated that Petitioner made a movement to recover his balance. (TX, p. 54) Mr. Sotelo waved his arms to indicate the type of motion that Petitioner made. Mr. Sotelo testified he was "like two or three feet" from Petitioner when this happened. (TX, p. 55) Mr. Sotelo stated that Israel Guarneros was also working on Petitioner's team and "would have seen [Petitioner] at most times during that night". (TX, p. 59)

According to Mr. Sotelo, Petitioner finished his shift that night and worked with him at least once more after that. (TX, p. 55)

On cross-examination, Mr. Sotelo testified that the stripper is a "very slippery liquid" and that it was common "for somebody to lose their balance a little". (TX, p. 57)

On re-direct examination, Mr. Sotelo denied ever being approached by anyone asking questions on behalf of Respondent related to the incident. When the question was re-phrased, Mr. Sotelo testified that "Valencia or someone from [Respondent]" asked him if he remembered the incident, but he could not recall whether Ms. Valencia asked him about the incident "within two weeks or less of the accident". (TX, p. 61) On re-cross examination, Mr. Sotelo testified that he was never asked to sign any kind of statement regarding what happened on August 23, 2013, (TX, p. 61)

Respondent's Medical Evidence

Petitioner attended two IME's with Dr. Daniel A. Troy at Respondent's request pursuant to Section 12 of the Act. Dr. Troy's IME report dated October 19, 2013 notes that Petitioner told Dr. Troy that he "slipped on a liquid that was on the floor and he subsequently fell forward catching himself on his two hands in front of him," with his right hand sustaining a "significant portion of the brunt of the force". (RX1, p. 1) Petitioner reported to Dr. Troy that he "twisted his back as he was falling and subsequently felt pain to his low back." (RX1, p. 1) Petitioner denied any prior history of back problems. (RX1, p. 3) Petitioner complained primarily of back pain but also had "intermittent complaints of pain going into his legs" but denied feeling any leg pain during his examination. (RX1, p. 3) Dr. Troy reviewed the available diagnostic testing concluding that the radiographs of the lumbosacral spine "demonstrated a Grade II lytic L5-S1 spondylolisthesis". (RX1, p. 4) The MRI films from September 4, 2013, demonstrated spondylolisthesis Grade II in nature, as well as disc bulges noted at L4-L5 and L5-S1. (RX1, p. 4) The doctor noted that the EMG/NCV performed on September 24, 2013, had "an overall impression showing evidence of a right L5 radiculopathy". (RX1, p. 5) Dr. Troy diagnosed Petitioner with a "lumbosacral strain" that was causally connected to his work accident. (Id)

However, Dr. Troy also added that Petitioner "has a profound, pre-existing condition at the lumbosacral spine with a Grade II lytic spondylolisthesis". (Id) He opined that Petitioner was capable of working light duty and could be released to full duty on November 11, 2013. (Id, p. 6)

On May 29, 2014, Dr. Troy conducted a second IME of Petitioner. Dr. Troy's report noted that Petitioner's description of his fall was "unchanged". (RX2, p. 5) He noted that Petitioner's "subjective complaints of pain appear to be secondary to the aggravation of the pre-existing L5-S1 lytic spondylolisthesis". (Id) The doctor noted that although "the lytic spondylolisthesis pre-dated the accident there is no documentation of the claimant having any care or treatment prior to the accident". (Id., pp. 5, 6) Dr. Troy opined that all the treatment to date had been reasonable and necessary. (RX2, p. 6) Dr. Troy stated that Petitioner "should strongly consider surgical intervention consistent [sic] of posterior spinal fusion, instrumentation and interbody cage placement". (Id.) Specifically, Dr. Troy recommended "an L4 to S1 posterior spinal fusion" since Petitioner also had "moderate degenerative changes at the L4-L5 level". (Id.) Petitioner would reach maximum medical improvement "six months following a posterior spinal fusion". (Id.)

On September 18, 2014, Dr. Troy issued an addendum report in which he modified his causation opinion. The doctor reiterated the need for surgical intervention. The doctor noted that if Petitioner "suffered a slip and fall and subsequently fell to the floor than [sic] one could argue that this was more than enough force to aggravate that pre-existing process". (RX3) However, if Petitioner "just slipped and caught himself, this would cause more of a muscular strain," which in his opinion "would not be a strong enough mechanism of injury to aggravate the long-standing, pre-existing process at the L5-S1 level". (RX3)

Respondent's produced five exhibits consisting of utilization and bill reviews. RX4 is a bill review of treatment received at La Clinica matching charges to the medical fee schedule. RX5 contains a bill review of additional charges from La Clinica, as well as charges from Meds Management Group. RX4 also contains a notice denying the need for an MRI from American Diagnostic MRI, LLC, pursuant to a utilization review (UR). RX6 contains UR reports addressed to La Clinica.

RX7 contains bill reviews for charges from Phamatech, Inc., Argus Medical Medical Supply, La Clinica, Lindenhurst Anesthesia, and APM Surgical Group. These letters state that "this claim is denied." A final bill review for charges from Metro Health Solutions stated the charges were denied as they reflected "treatment that is not reasonable or necessary."

RX8 is a UR of bills from Lindenhurst Anesthesia and APM Surgical Group. The first page of the exhibit is a cover letter dated October 13, 2014, stating that the bills from Lindenhurst Anesthesia were denied because "the charges represent treatment that is not reasonable or necessary." The letter states that this decision was "based on the IME dated October 19, 2013".

CONCLUSIONS OF LAW

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

Petitioner presented as a credible witness. The Arbitrator carefully scrutinized his demeanor as he testified and perceived him to be straightforward and honest. His testimony as to his accident was consistent on both direct examination and cross-examination.

The Arbitrator notes that Petitioner's live testimony is consistent with the history he presented to Dr. Troy at his IME examinations.

Israel Guarneros presented as a credible witness. He was the supervisor of the maintenance work for Catherine Cook School at the time of the accident, and still worked for Respondent as of the date of hearing. Mr. Guarneros presented at the hearing as natural and relaxed while testifying. Mr. Guarneros testified that he was the closest person to Petitioner, standing "about five or six feet" away when the accident occurred. (TX, p. 30-31) According to Mr. Guarneros, Petitioner slipped on the floor causing him to fall onto the floor, landing on his hands and knee. Mr. Guarneros' recollection that Ms. Valencia told Petitioner to "be careful" (TX, p. 34) is consistent with Ms. Valencia's testimony that she told Petitioner to "be careful". (TX, p. 44) When questioned about giving the Petitioner a ride to La Clinica, Mr. Guarneros replied that Petitioner does not drive. (TX, p. 38) His reply is corroborated by records from La Clinica that note that Petitioner could not make a follow-up appointment with Dr. Koutsky because he did not have transportation. (PX1, p. 180) According to Mr. Guarneros, on one occasion a female supervisor asked him if "he had seen that Israel [sic] had fallen; and I told her yes". (TX, p. 38)

The Arbitrator notes that Cutberto Sotelo appeared very nervous at the hearing and he mumbled throughout his testimony. Mr. Sotelo denied being questioned soon after the fact about Petitioner's August 23, 2013 accident, (TX, pp. 60, 61) and denied ever making a written statement regarding the accident. (TX, p. 61) Mr. Sotelo did testify that "Valencia or someone from [Respondent]" asked him if he remembered the incident, but he could not recall whether he was asked about the incident "within two weeks or less of the accident". Mr. Sotelo recalled that Petitioner "slipped" and "lost control" but "did not fall to the floor". (TX, p. 54) Mr. Sotelo stated that Petitioner made a movement to recover his balance. (TX, p. 54) On cross-examination, Mr. Sotelo testified that the floor stripper is a "very slippery liquid" and that it was common "for somebody to lose their balance a little". (TX, p. 57)

It is unclear from the testimony of Respondent's witnesses what, if any, investigation was made immediately after the accident that could corroborate their testimony. No accident or written statements were offered as evidence by Respondent. The Arbitrator notes that the only witness who testified clearly to being asked about the accident was Mr. Guarneros, who stated that he told the person asking questions on behalf of Respondent that Petitioner fell. Ms. Valencia testified that she relayed Petitioner's report of an accident to her boss.

The Arbitrator does not place much weight on RX3, Dr. Troy's addendum report, since Dr. Troy changed his causation opinion at the prompting of Respondent's counsel a month before trial.

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to his injury.

Dr. Dixon, Dr. Koutsky, and Dr. Troy all agree that Petitioner suffers from grade 2 spondylolisthesis at L5-S1 and should have surgery for this condition. Dr. Dixon and Dr. Koutsky also agree that Petitioner's current condition of ill-being is related to his work accident of August 23, 2013, which aggravated a pre-existing condition in Petitioner's lumbar spine. Dr. Troy in his second report also stated that on August 23, 2013, Petitioner suffered an aggravation of his pre-existing lumbar spine condition. His only caveat was spelled out in his third report (prompted by a letter from Respondent's counsel) having to do with the mechanism of the accident. Dr. Troy's position is essentially that if Petitioner landed on the ground, as he stated at his IME, then the proposed surgery is causally related to his work accident; if he did not hit the ground, then the surgery, while reasonable and necessary, is not causally related. Therefore, Respondent's only possible reason for denying Petitioner's claim is because Petitioner allegedly did not fall to the ground on August 23, 2013.

The Arbitrator places more weight on the testimony of Petitioner and his eyewitness, Israel Guarneros, than that of Respondent's witnesses. Petitioner's account of his accident at trial was consistent with the account he gave to Dr. Troy at his first IME. His account was confirmed by Mr. Guarneros, who was his supervisor at the time and is still employed by Respondent. It is unclear from the testimony of Respondent's witnesses whether they carried out any kind of accident investigation. Ms. Valencia testified only that she forwarded Petitioner's accident report to her supervisor. The Arbitrator notes that Petitioner's claim was initially approved and $4,637.02 in TTD benefits that were paid to Petitioner. (AX1)

Mr. Guarneros testified that he told a woman who worked for Respondent that Petitioner did fall to the ground.

The Arbitrator notes two additional facts that speak in favor of Petitioner's account of the accident and therefore of a finding that Petitioner's current condition of ill-being is causally connected to his accident. The first is the sudden onset of pain and medical treatment. Before August 23, 2013, Petitioner was gainfully employed in a physically demanding job, but soon afterwards he had to stop working because of low back pain. Since his first visit to La Clinica on September 3, 2013, Petitioner has constantly been under a doctor's care for back pain, which has been documented by objective diagnostic testing and spine specialists, including Respondent's IME physician. Second, despite having a pre-existing condition of the lumbar spine, Petitioner has no history of back pain before August 23, 2013. As Dr. Troy noted, "there is no documentation of the claimant having any care or treatment prior to the accident". (RX2, pp. 5, 6) The Arbitrator notes that the medical records reflect a sudden onset of back pain as well as consistent medical treatment since September of 2013. Based on the credible medical evidence as wells as the credible testimony of Petitioner and Mr. Guarneros, the Arbitrator concludes that Petitioner suffered a traumatic fall on August 23, 2013 and that Petitioner's current condition of ill-being is causally connected to the fall he sustained while working on August 23, 2013.

In regards to the Arbitrator's decision on issue (J), whether all 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:

Based on the foregoing finding that Petitioner's current condition of ill-being is causally connected to his work accident, the Arbitrator concludes that the medical services provided to Petitioner were reasonable and necessary and that Respondent has not paid all appropriate charges for these services.

The Arbitrator notes that all three spine surgeons who have examined Petitioner agree that he has a serious condition of his lumbar spine, namely grade 2 spondylolisthesis. This condition was only discovered through the aid of diagnostic testing, namely the MRI and the EMG. Therefore, the Arbitrator discounts RX5, which denied the reasonableness of the MRI.

Petitioner's conservative treatment was also reasonable in that it did aid Petitioner in temporary pain relief. Furthermore, in his second report, Dr. Troy opined that all the treatment through May 29, 2014, had been reasonable and necessary. (RX2, p. 6)

The Arbitrator therefore orders Respondent to pay Petitioner's outstanding medical bills, which were submitted into evidence as Petitioner's exhibit #4 (PX4), as well as those included in Respondent's exhibits #4, #5, #6, #7, and #8, pursuant to Section 8(a) of the Act, but subject to the limitations of the medical fee schedule and Section 8.2 of the Act. The Arbitrator has reviewed the medical fee schedule analysis submitted by Petitioner and finds that the amount of medical bills due pursuant to the medical fee schedule is $43,885.07.

The Arbitrator finds that the UR reports lack credibility. One UR report (contained in RX5) denied an MRI scan as an unnecessary medical cost. Given the serious nature of Petitioner's injury to his back, Respondent's denial is unreasonable. Another UR report, produced two days before trial, denied certain bills as unreasonable based on Dr. Troy's first IME report of October 2013, without mentioning the fact that in his second IME report of May 2014, he opined that all of Petitioner's treatment to date was reasonable and necessary.

In regards to the Arbitrator's decision on issue (K), whether Petitioner is entitled to any prospective medical care, the Arbitrator finds the following:

The Arbitrator concludes that Petitioner is entitled to prospective medical care, specifically a lumbar spinal fusion with instrumentation.

All three spine surgeons who have examined Petitioner agree that he has grade 2 spondylolisthesis and needs surgery. All three agree that the surgery he needs is a lumbar spinal fusion with instrumentation. Their opinions are based on the diagnostic evidence, the findings on the MRI, which were consistent with the EMG findings. Finally, after Petitioner's failure to improve significantly after physical therapy and injections over the course of over a year, it is reasonable to consider surgical solutions for Petitioner's back pain.

Therefore, the Arbitrator concludes that Petitioner is entitled to prospective medical care to be approved and paid for by Respondent, namely a lumbar spinal fusion with instrumentation, as recommended by both Petitioner's treating physicians and Respondent's IME physician.

In regards to the Arbitrator's decision on issue (L), whether TTD benefits are owed to Petitioner, the Arbitrator finds the following:

The Arbitrator concludes that Respondent owes Petitioner TTD benefits in the amount of $13,504.41.

Respondent agrees that Petitioner was temporarily totally disabled and entitled to TTD benefits from September 3, 2013, through November 11, 2013. The three spine surgeons who have examined Petitioner agree that he needs a lumbar spinal fusion and therefore has not yet reached maximum medical improvement. Since the date of the accident, Petitioner's treating physicians have either taken him completely off of work or given him light duty restrictions that could not be accommodated by Respondent. Petitioner's doctors have consistently stated that he should not squat or bend; however, as Petitioner's job mopping floors would require constant bending, Petitioner has been off work since September 3, 2013, through the date of hearing (October 15, 2014), for a total of 58 and 2/7 weeks.

The parties agree that Petitioner's average weekly wage is $466.87 and that he is single with one dependent child. This yields a TTD rate of $311.25. Petitioner is therefore entitled to $18,141.43 in TTD benefits. Respondent shall be allowed a credit of $4,637.02 for TTD benefits it has already paid. Petitioner is therefore owed a balance of $13,504.41 in TTD benefits.

In regards to the Arbitrator's decision on issue (M), whether penalties and fees should be imposed upon Respondent, the Arbitrator finds the following:

The Arbitrator concludes that Respondent is liable for attorney's fees and penalties, pursuant to Section 16, 19(k) and 19(l) of the Act.

Under Section 19(l), "in case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay." 820 ILCS 305/19(l). An award of Section 19(l) penalties does not depend on a showing of objectively unreasonable or vexatious behavior; rather, such penalties are in the nature of a non-discretionary "late fee." McMahan v. Indus. Comm'n., 183 Ill.2d 499, 515 (1998).

Section 16 of the Act provides that whenever an employer, its service company, or insurance carrier "has been guilty of unreasonable or vexatious delay, intentional under-payment of

compensation benefits, or has engaged in frivolous defenses which do not present a real controversy within the purviews of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier." 820 ILCS 305/16. Section 19(k) of the Act further authorizes the Commission to award "compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award." 820 ILCS 305/19(k).

The Arbitrator finds that Respondent's defense was objectively vexatious and unreasonable for the following reasons. First and foremost, Respondent's primary defense at trial—that Petitioner did not fall to the ground—was not reasonable given the lack of evidence related to any accident investigation. From the testimony of Respondent's witnesses it is clear that Respondent did not interview all the witnesses or take down any written statements. Ms. Valencia, whom Mr. Guarneros identified as his supervisor at the jobsite, testified only that she forwarded Petitioner's report of an accident to her supervisor. The Arbitrator notes that Ms. Valencia testified that she *did not* tell her boss that Petitioner *did not fall*, a strikingly important fact to withhold from her boss under the circumstances. Mr. Sotelo could not remember whether "Valencia or anyone from [Respondent]" had spoken to him about the accident around the time that Petitioner stopped going to work but does remember someone speaking to him on behalf of Respondent. At trial, Respondent did not produce any written statements with respect to Petitioner's accident.

Mr. Guarneros testified that he told an unnamed woman who worked for Respondent that Petitioner did fall to the ground. In light of this fact, it appears that Respondent excluded or ignored Mr. Guarneros statement that Petitioner fell to the ground.

The Arbitrator notes that Dr. Troy modified his causation opinion only after being asked by Respondent's counsel, approximately one month before trial, about how a different mechanism of accident than that reported by Petitioner would affect his opinion. Dr. Troy never mentioned in any of his reports being asked to review any witness statements regarding the accident. The Arbitrator finds it strange that such essential information would be withheld from Dr. Troy by Respondent until after Dr. Troy wrote in his second IME report that Petitioner needed a lumbar spinal fusion that was related to his work accident.

The Arbitrator notes that Respondent's reliance on its UR reports is flawed. One UR report (contained in RX5) denied an MRI scan as an unnecessary medical cost. Given Petitioner's serious injury to his back, Respondent's reliance was unreasonable. Another UR report, produced two days before trial, denied certain bills as unreasonable based on Dr. Troy's first IME report of October 2013, without mentioning the fact that in his second IME report of May 2014, he opined that all of Petitioner's treatment to date was reasonable and necessary.

RX6 contains UR reports addressed to La Clinica. The Arbitrator notes that none of these mention the May 29, 2014 IME with Dr. Troy in which the doctor noted that Petitioner's "subjective complaints of pain appear to be secondary to the aggravation of the pre-existing L5-S1 lytic spondylolisthesis". (Id) The doctor noted that although "the lytic spondylolisthesis pre-dated the accident there is no documentation of the claimant having any care or treatment prior to the accident". (Id., pp. 5, 6) Dr. Troy opined that all the treatment to date had been reasonable and necessary. (RX2, p. 6) RX7 contains bill reviews for charges from Phamatech, Inc., Argus

Medical Medical Supply, La Clinica, Lindenhurst Anesthesia, and APM Surgical Group. These letters simply state that "this claim is denied." A final bill review for charges from Metro Health Solutions stated the charges were denied as they reflected "treatment that is not reasonable or necessary." RX8 is a UR of bills from Lindenhurst Anesthesia and APM Surgical Group. The first page of the exhibit is a cover letter dated October 13, 2014, two days before the date of arbitration hearing, stating that the bills from Lindenhurst Anesthesia were denied because "the charges represent treatment that is not reasonable or necessary." The letter states that this decision was "based on the IME dated October 19, 2013," nearly five months after Dr. Troy's second IME report concluding that Petitioner's treatment up to that point had been reasonable.

The Arbitrator finds that Respondent's reliance on Dr. Troy's IME reports and UR's as a basis deny Petitioner's claim for medical care and TTD benefits has been objectively unreasonable.

For these reasons, the Arbitrator finds that Respondent's defense of this claim has been unreasonable and vexatious. The Arbitrator concludes that Respondent should be held liable for Section 16 attorney's fees, Section 19(k) penalties, and Section 19(l) additional compensation. The time of unreasonable delay in payment commenced on November 12, 2013 (the date on which Dr. Troy originally predicted Petitioner would be MMI), and continued through the date of hearing, which is a delay of 48 and 2/7 weeks. Respondent must therefore pay $10,000.00 in additional compensation pursuant to Section 19(l).

The amount of TTD benefits due on the day of the hearing was $13,504.41. The amount of medical bills due pursuant to the medical fee schedule is $43,885.07. The total amount due at the time hearing, then, was $57,389.48. The attorney's fees due under Section 16 are $11,477.89 (20% of $57,389.48). The penalties due under Section 19(k) are $28,694.74 (50% of $57,389.48).

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alayna Riden,
Petitioner,

vs.

State of Illinois,
Illinois Youth Center-Harrisburg,
Respondent.

NO. **10 WC 033880**
10 WC 033879
10 WC 033878
11 WC 001277
11 WC 010290
11 WC 010291

16IWCC0398

DECISION AND OPINION PURSUANT TO SECTIONS 19(h) AND 8(a)

Petitioner appears before the Commission on a Petition under Section 19(h) and Section 8(a) of the Worker's Compensation Act, alleging a material increase in her disability and requesting payment of additional medical expenses and temporary total disability benefits subsequent to the decision of Arbitrator Lee filed on August 6, 2012. Petitioner had filed six Applications for Adjustment of Claim for exposure to Methicillin Resistant Staphylococcus Aureas (MRSA). The claims were consolidated and the matter was tried before the Arbitrator in June 2012. The Arbitrator awarded Petitioner medical expenses of $2,815.00 under Sections 8(a) and 8.2 and found permanent partial disability to the extent of 4% loss of the person as a whole under Section 8(d)2.

Petitioner filed the instant Sections 19(h)/8(a) Petition on May 3, 2013. A hearing was held before Commissioner White in Mt. Vernon, Illinois on August 6, 2015. The Commission, after considering the entire record, grants the Petition as to Section 19(h), finding that Petitioner is entitled to an award representing an additional 3.5% loss of use of the person as a whole. Further, the Commission grants the Petitioner as to Section 8(a), finding that Petitioner is entitled to payment of reasonable and necessary medical expenses as set forth in Petitioner's Exhibit 3, excluding those uncorroborated charges as discussed below. The Commission also awards 1 and 1/7 weeks of temporary total disability benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The record demonstrates that, at all relevant times, Petitioner was employed as a records office supervisor at Illinois Youth Center Harrisburg, a detention facility for youth offenders. At the age of 35, she contracted a MRSA infection. Around May 20, 2010, she had developed swelling and pain in her right cheek area. A pustule on her cheek was lanced, cultured, and tested positive for a moderate growth of MRSA. She filed six Applications for Adjustment of Claim in all, following outbreaks on July 30, 2010, August 23, 2010, November 22, 2010, February 22, 2011 and February 28, 2011. The claims were consolidated and heard before Arbitrator Lee on June 14, 2012. On August 6, 2012, the Arbitrator filed his decision, finding that Petitioner had sustained an accident that arose out of and in the course of employment. As to the issue of causation, the Arbitrator found that Petitioner was exposed to an increased risk not faced by the general public. He noted evidence, including her testimony, that in her employment Petitioner came in direct contact with youth inmates who were infected with MRSA. He noted that subpoenaed records showed not only that she was a direct caregiver for these youths (in which capacity she came in physical contact with them, their belongings and soiled dressings), but these youths were also infected with MRSA.

Petitioner's treating physician Dr. James Alexander testified as to the recurring nature of the MRSA infection, stating that once infected, Petitioner was more likely to be re-infected and would need to take several preventative health measures to prevent future infection. Petitioner testified regarding the condition's impact on her daily activities, including the requirement now that she bleaches the shower and towels after using them. As mentioned earlier, the Arbitrator found that her injuries caused her permanent partial disability to the extent of 4% loss of the person as a whole. Neither party filed a Petition for Review of the Arbitrator's Decision, which became final.

At the 19(h)/8(a) hearing of August 6, 2015, Petitioner testified that, since the Arbitrator's Decision of August 6, 2012, she has had at least five additional MRSA outbreaks for which she sought treatment.[1] Medical records show that she was hospitalized twice: from May 30, 2013 through June 3, 2013 at Harrisburg Medical Center, and from May 28, 2014 through May 30, 2014 at Herrin Hospital, to treat outbreaks on her chin and left hand, respectively. These hospitalizations were followed by daptomycin antibiotic infusions through a PICC line (peripherally inserted central catheter line) inserted in the arm. She underwent these near-daily infusions from June 27, 2013 through July 9, 2013, and from June 1, 2014 through June 17, 2014. She had also had an infusion at St. Joseph's Memorial Hospital on June 26, 2013.

---

[1] Petitioner had outbreaks on her abdomen (11/26/12); left eye (12/27/12); nasal fold (4/5/13); chin spreading to neck and mouth (5/24/14); and left hand and right thigh (5/28/14).

Petitioner testified that she missed several days of work; she was taken off work from May 30, 2013 through June 10, 2013 by Dr. Alexander in connection with the first hospitalization. She attested that her treatment has been a "little more frequent" since the date of the Arbitrator's Decision, and she takes oral medications every other month. There was a readily visible half- to three-quarter-inch scar on her chin; she testified that other scars resulting from the outbreaks on the lip and eyes have faded.

At the time of the 19(h)/8(a) hearing, Petitioner was 40 years old. She was still employed in the same position by Respondent and was not under any work restrictions. Respondent, in its brief, did not dispute her entitlement to an additional permanent partial disability award but contended that the award should be 2% loss of the person as a whole, whereas Petitioner sought an additional 5%. Respondent did not dispute the issue of temporary total disability. As to additional medical expenses, Respondent did not dispute the medical bills submitted by Petitioner other than to note that no corroborating medical records were entered into evidence for those bills that were attributed to visits made to Dr. Alexander prior to November 26, 2012.

Based on the above, the Commission concludes that Petitioner has proven a material increase in her disability since the Arbitrator's Decision of August 6, 2012 to the extent of an additional 3.5% of the person as a whole. Taking into account that prior Arbitrator's Decision, the Commission finds the total percentage loss that Petitioner has sustained as the result of her work-related MRSA exposure is 7.5% of the person as a whole under Section 8(d)(2). The Commission also finds that she has proven entitlement to payment of additional medical expenses, excluding those expenses for which there were no corroborating medical records, as discussed. The Commission also awards 1 and 1/7 weeks of temporary total disability benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under Sections 19(h) and 8(a) is granted to the extent discussed above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $ 593.85 per week for a period of 17.5 weeks, as provided in Section 19(h) of the Act, for the reason that Petitioner sustained a material increase in her permanent disability to the extent 3.5% loss of the person as a whole. As a result of her work-related exposure to MRSA, Petitioner is now permanently disabled to the extent of 7.5% of the person under Section 8(d)(2).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the medical bills described in Petitioner's Exhibit 3, excluding the amounts attributed to visits to Dr. Alexander prior to November 26, 2012, as provided by Section 8(a).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $ 663.33 per week for a period of 1-1/7 weeks, that being the period of Petitioner's additional temporary total incapacity for work, as provided by Section 8(b).

16IWCC0398

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

DATED: JUN 14 2016

Joshua D. Luskin

o-04/13/16
jdl/ac
68

Ruth W. White

Charles J. DeVriendt

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ebtessam Khamissi,
Petitioner,

vs. NO: 12 WC 44245

16IWCC0399

Phonak, LLC,
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 sole issue of the nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The underlying facts of this claim were well laid out in the Arbitrator's Decision, which is incorporated herein, and the Arbitrator's findings of fact are adopted. With regard to the nature and extent of the injury, however, the Commission reviews and weighs the facts somewhat differently than did the Arbitrator. Specifically, the Commission takes note of the fact that while the claimant did suffer a fractured tailbone, she lost less than two months' time from work prior to her returning to full time employment. Moreover, while Dr. Koutsky, her treating physician, had at one point recommended consideration of sacroplasty, he later withdrew that recommendation, concluding that the fractured coccyx had sufficiently healed independently; this conclusion was shared by Dr. Xia, the Section 12 examiner. While at trial she asserted persistent symptoms despite lumbar injections, the Commission finds it more informative that she returned to her usual and customary occupation in April 2012 and worked full time for three years in that capacity before her termination for unrelated reasons.

16IWCC0399

In light of the above, the Commission finds an award of permanent partial disability of 12.5% loss to the whole person to be more in line with the extent of the injuries sustained, and modifies the Arbitrator's award accordingly. All other findings of the Arbitrator are affirmed, including the Arbitrator's awards of temporary total disability and medical costs.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $301.86 per week for a period of 5-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $271.68 per week for a period of 62.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of the whole person to the extent of 12.5%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,700.16 for medical expenses under §8(a) 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 $18,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 14 2016

Joshua D. Luskin

o-06/08/16
jdl/jl
68

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KHAMISSI, EBTESSAM
Employee/Petitioner

Case# **12WC044245**

PHONAK LLC
Employer/Respondent

16IWCC0399

On 11/10/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0103 RUTH STELZMAN PC
PO BOX 279
NORTH AURORA, IL 60542

2837 LAW OFFICES JOSEPH MARCINIAK
BRENT HALBELIB
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ebtessam Khamissi
Employee/Petitioner
v.
Phonak, LLC
Employer/Respondent

Case #12 WC 44245

16IWCC0399

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Jessica A. Hegarty, Arbitrator of the Commission, in the city of Wheaton, on 8/19/15. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On, 2/14/12 Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**23,545.60**; the average weekly wage was $**452.80**.

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

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

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

Respondent shall be given a credit of $**1,577.44** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,577.44**.

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 of $1,700.16, as provided in Section 8(a) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $301.86/week for 5 5/7 weeks, commencing 2/15/12 through 2/16/12, 2/21/12 through 2/24/12, and 2/28/12 through 4/1/12.

Respondent shall be given a credit of $1,577.44 for temporary total disability benefits that have been paid.

Permanent Parital Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $271.68 per week for 112.5 weeks, because the injuries sustained caused the 22½ % disability, as provided in Section 8(d-2) of the Act.

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

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

Signature of Arbitrator

11/3/15
Date

NOV 10 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

EBTESSAM KHAMISSI)
Petitioner,)
)
Vs.)
)
PHONAK, LLC)
Respondent

No. 12 WC 42245
Wheaton

16IWCC0399

ADDENDUM TO THE DECISION OF THE ARBRITATOR

This matter proceeded to hearing on August 19, 2015, in Wheaton, Illinois before Arbitrator Jessica A. Hegarty.

Respondent has stipulated to all issues except causal connection and nature and extent of the injury. (Arb. 1).

FINDINGS OF FACT

Ebtessam Khamissi ("Petitioner") was an employed by Phonak, LLC., ("Respondent") as a technician in the production of hearing aids. She testified that she sat down during her job.

On February 14, 2012, Petitioner was involved in an undisputed accident when she fell off a broken stool and landed on her back and buttocks while opening mail. Petitioner noted pain in her tailbone area as a result of the fall. She was treated that day at Edward Hospital Occupational Health where she complained of low back pain. Petitioner continued to treat at Edwards Hospital Corporate Health from February, 2012 until October of 2012 (PX 9).

On March 7, 2012, Petitioner underwent an MRI of her sacrum that showed a non-displaced fracture extending transversely through the sacral segment.

Petitioner was treated by Dr. Andreshak and Dr. Vinita Matthew at Orthopedic Associates of DuPage, where she was diagnosed with low back pain and a fractured sacrum/coccyx (PX 10). She was also treated by Dr. Paul Belich at Loyola University who diagnosed her with Coccydynia and opined that she was not a good candidate for surgery. Dr. Belich recommended sacral nerve blocks and sacral coccygeal plexus blocks in a pain clinic (PX 7).

On April 19, 2013, Dr. Kevin Koutsky of Elmhurst Orthopedics diagnosed Petitioner with a sacral fracture and chronic pain. Petitioner continued to treat with Dr. Koutsky until October of 2013. (PX3).
Petitioner was referred to Dr. Humaira Khatoon, a pain management doctor, by Dr. Koutsky who performed three bilateral sacroiliac joint steroid injections on 7/8/13, 7/29/13, 9/9/13 (PX5).

Petitioner underwent conservative care including physical therapy. Petitioner returned to work without restrictions on April 2, 2012. It was recommended Petitioner sit on a donut for work.

Petitioner worked full duty for the Respondent from April 2, 2012 to April, 2015 when she was terminated. She testified that she was able to perform her job duties during that the 3 year period.

Dr. Koutsky opined in his June 9, 2014, report that the Petitioner's sacral fracture was well healed and that she did not need a sacroplasty.

Dr. Tian Xia, Respondent's Independent Medical Evaluation doctor, diagnosed Petitioner with a non-displaced fracture of the sacrum/coccyx and opined that a sacroplasty would not be effective or necessary. Dr. Xia found Petitioner's subjective complaints of pain supported by his exam. The doctor opined that the capacity in which Petitioner returned to work should be determined by a Functional Capacity Evaluation. Dr. Xia further opined and that Petitioner's condition resulted from work accident. Dr. Xia did not anticipate Petitioner would return to her pre-injury status.

On February 14, 2015, a Functional Capacity Evaluation concluded that Petitioner has the physical capacity to perform sedentary work, with ergonomic recommendations of an oversized chair to accommodate her large girth and allow for the placement of a lumbar roll or support behind her lower back to diminish direct pressure on the coccyx, as well as an angled foot-rest to accommodate her short stature. It was also concluded that Petitioner should be allowed occasional breaks of five minutes every hour to get out of a chair to intermittently relieve pressure on the coccyx. It is noted that Petitioner was working full duty at the time of the FCE and had been for nearly 3 years.
(PX 1)

Petitioner testified that she was terminated from Phonak in February, 2015 and is currently seeking employment.

Petitioner testified that she is in a constant state of pain. She testified the pain feels like she is being hit with "lashes" all the time. Petitioner currently treats with her family physician who prescribes medication for her pain.

Petitioner's Exhibit 11 is a bill in the amount of $1,700.16 from Lakeshore Sports Physical Therapy for the Functional Capacity Evaluation conducted on February 14, 2015. The Respondent had no objection to this exhibit.

CONCLUSIONS OF LAW

Is Petitioner's current condition of ill being causally connected to the injury?

The Arbitrator finds that the Petitioner's condition of ill being is casually connected to the injuries she sustained at work on February 14, 2012. The Arbitrator relies on the medical records of Edwards Hospital, Orthopedic Associates of DuPage, Elmhurst Orthopedics and the June 9, 2014 letter authored by Dr. Koutsky, as well as Respondent's Independent Medical Examination, performed on December 3, 2013 by Dr. Tian Xia with respect to this finding.

The Arbitrator also places significant weight upon the unrebutted testimony of Petitioner whom the Arbitrator found to be credible. Petitioner testified that she continues to experience pain all of the time. She testified that her pain feels like she is continuously being hit with "lashes". Petitioner testified that when she sits she has a lot of pain and that when she stands she has a lot of pain . Petitioner treats with her family doctor who prescribes pain medication. The Arbitrator finds Petitioner's current complaints to be supported by the medical evidence in the record.

Nature and Extent of the Injury

For injuries occurring on or after September 1, 2011, all permanent partial disability awards shall be established using the following criteria under Section 8.1b of the Act:

(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 employees's future earning capacity; and
(v) Evidence of disability corroborated by the treating medical records.

No single factor shall be the sole determinant of disability, the weight given to each factor must be explained in the written arbitration decision.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, Petitioner was employed as a technician in the manufacture of hearing aides. Petitioner sat while she was working on the hearing aides. Although she returned to her pre-injury job with Respondent, Petitioner was terminated in February of 2015 and, as of the date of the hearing, continues to look for work. The Arbitrator notes the medical records corroborate the fact that Petitioner was in pain while she performed her job duties for

Respondent after the accident. Based on the fact that Petitioner was terminated by Respondent after performing her pre-injury job in pain for three years, the Arbitrator assigns *less* weight to this factor in her determination of a PPD award.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident. The Arbitrator considers Petitioner's age to be *somewhat* advanced in age. The Arbitrator therefore finds this factor to be relevant in her PPD analysis and assigns *greater* weight to this factor.

With regard to subsection (iv) of §.1b(b), Petitioner's future earnings capacity, although the Petitioner had returned for 3 years to work for the Respondent, the Arbitrator finds this fact is mitigated by the treating medical records that reflect persistent complaints of pain from the time of the accident through the 2/14/15 FCE. The Arbitrator also notes Dr. Tian Xia, Respondent's Independent Medical Evaluation doctor, did not anticipate Petitioner would return to her pre-injury status. The Arbitrator also notes that the FCE examiner determined that Petitioner could only work in a sedentary capacity.

Petitioner testified that Respondent terminated her in February of 2015 and that she has been looking for employment since that time. The Arbitrator further takes notice of the fact that Petitioner does not speak English and required the services of a Farsi interpreter at the arbitration hearing.

The Arbitrator finds the above facts relevant in the determination of future earning capacity and therefore gives *greater* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes:

- The 3/7/12, MRI of Petitioner's sacrum that showed a non-displaced fracture extending transversely through the sacral segment.

- Dr. Bellich's 12/26/12 note where Petitioner reported attending 2 physical therapy sessions with "very minimal relief." The doctor further noted "she gets pain with sitting and also pain with prolonged standing." Petitioner reported that she was currently working in a factory making hearing aides and that she sits on a "cushion-type device." (PX7).

- The treating records of Dr. Andreshak and Dr. Vinita Matthew which notes a diagnosis of low back pain and a fractured sacrum/coccyx (PX 10).

- The treating records of Dr. Paul Belich at Loyola University who diagnosed Petitioner with Coccydynia and opined that she was not a good candidate for surgery. Dr. Belich recommended sacral nerve blocks and sacral coccygeal plexus blocks in a pain clinic (PX 7).

- The treating records of Dr. Kevin Koutsky of Elmhurst Orthopedics in which he diagnosed Petitioner with a sacral fracture and chronic pain.

- The 4/19/13 note from Dr. Koutsky in which Petitioner presented with chronic sacral pain. On exam, paralumbar and parasacral tenderness to palpation with minimally limited range of motion was noted.

- The pelvic MRI performed on 4/26/13 indicating "chronic deformity at the sacrococcygeal junction probably chronic residue from old fracture deformity."

- Dr. Koutsky's 6/5/13 note in which Petitioner reported chronic lower back and sacral pain. Petitioner's pain medication was refilled.

- The treating records of Dr. Humaira Khatoon, who performed three bilateral sacroiliac joint steroid injections on 7/8/13, 7/29/13, 9/9/13.

- The 7/8/13 notation by Dr. Khatoon in which Petitioner reported tailbone pain for the past 2 years. Sitting, walking and standing were reported as exacerbating factors. On exam, paraspinal and SI joint tenderness was noted.

- Dr. Khatoon's 7/29/13 note reflecting Petitioner's medications included hydrocodone, flexeril, meloxicam (NSAID) and ibuprofen.

- The 10/4/13 notation by Dr. Koutsky in which Petitioner reports "a fair amount of pain in the back despite therapy and 3 injections. She has been working full duty with the exception of taking 5 minute breaks as needed to change positions." The doctor noted that she "has failed conservative management including medications, therapy, and injections. She continues to have symptoms that interfere with her functions." Petitioner was diagnosed with lumbosacral pain and radiculitis and her pain medications were refilled.

- The February 14, 2015, FCE that concluded Petitioner has the physical capacity to perform sedentary work, with ergonomic recommendations of an oversized chair to accommodate her large girth and allow for the placement of a lumbar roll or support behind her lower back to diminish direct pressure on the coccyx, as well as an angled foot-rest to accommodate her short stature. It was also

concluded that Petitioner should be allowed occasional breaks of five minutes every hour to get out of a chair to intermittently relieve pressure on the coccyx. (PX 1)

Given that the aforementioned records do support and corroborate Petitioner's testimony with respect to chronic pain and disability, the Arbitrator assigns *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 22½ % loss of use of her body as a whole pursuant to §8(d)(2) of the Act. Respondent shall pay_Petitioner permanent partial disability benefits of $271.68 per week for 112.5 weeks.

Temporary Total Disability

Respondent stipulated that Petitioner was entitled to temporary total disability benefits of $301.86/week for 5 5/7 weeks, commencing 2/15/12 through 2/16/12, 2/21/12 through 2/24/12, and 2/28/12 through 4/1/12.

Respondent shall be given a credit of $1,577.44 for temporary total disability benefits that have been paid.

Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The parties agree that Respondent has not paid the bill for the Functional Capacity Evaluation from Lakeshore Sports Physical Therapy in the amount of $1,700.16. There being no objection by Respondent to this Exhibit, the Arbitrator finds that Respondent is liable for the Functional Capacity Evaluation bill in the amount of $1,700.16.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

☒ 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 Ann Woodward,
Petitioner,

vs.

St. Mary's Hospital,
Respondent.

16IWCC0400

NO: 10 WC 4520

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 15, 2015, is hereby affirmed and adopted.

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

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

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

DATED: JUN 15 2016
o6/7/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0400

WOODWARD, MARY ANN
Employee/Petitioner

Case# 10WC004520

ST MARY'S HOSPITAL
Employer/Respondent

On 9/15/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.26% 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:

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

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
120 W STATE ST PO BOX 1288
ROCKFORD, IL 61105

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSALLE)

16IWCC0400

- ☐ 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 ANN WOODWARD
Employee/Petitioner

v.

ST. MARY'S HOSPITAL
Employer/Respondent

Case # **10** WC **4520**

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 **Ottawa**, on **8/28/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **1/12/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**34,299.20**; the average weekly wage was $**659.60**.

On the date of accident, Petitioner was **69** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Petitioner failed to prove accident and causal connection. All benefits are denied.

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

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

Signature of Arbitrator

9/9/15
Date

SEP 15 2015

16IWCC0400

FINDINGS OF FACT

This is a claim for benefits in which the Petitioner is alleging a repetitive trauma accident on January 8, 2008 to her "right hand and other body parts." (See Application for Adjustment of Claim, Arb. Exh. 2) At the beginning of the hearing, the parties discussed the Application for Adjustment of Claim and agreed to amend the Application to change the accident date to January 12, 2010. Petitioner's motion to amend the Application was granted and the changes are reflected in the "1st Amended Application for Adjustment of Claim," which is part of Arbitrator's Exhibit 2. At issue in this case are the following: 1) accident, 2) notice, 3) causation, 4) medical expenses, 5) TTD, and 6) nature and extent. (See Arb. Exh. 1)

Petitioner testified that she worked for the hospital as essentially a "secretary" starting in July of 1979. She outlined her work duties as a secretary, and during the course of her testimony on direct examination, she described her work duties which were varied. This included typing, taking dictation, answering the phone, making copies, filing and surveying. She testified that she performed activities such as filing about one to two hours a day. She would type approximately four hours a day. She would answer the phones about one hour a day. She would write about every other day about a half hour to an hour per day. She described when she would file that she would hold her left arm close to her body with her left hand bent and close to her chest bending her elbow to greater than 90 degree angle. She testified that when she typed her left arm was in the position where her left arm was bent at greater than a 90 degree angle. She also testified that she would answer the phone with her left hand and hold the phone up to her ear bending her left arm at greater than a 90 degree angle. She testified that as she performed these job duties she noticed pain and numbness in the fingers of her hand. She testified that she rarely did one part of her work duties more than a couple hours a day, although there were occasions where she would spend more than two hours on a particular project. She went to great lengths to state that she would do many of her daily activities with her left arm "bent" at the angle of greater than 90 degrees. She testified that she was terminated as an employee in October of 2009. She further testified that she did not say anything to the employer about her alleged left elbow/hand condition prior to the time that she stopped working.

Petitioner first sought medical treatment with Dr. Sinha on January 12, 2010, approximately three months after she stopped work for the Respondent in October of 2009. (PX 2 and 3) According to the records, Petitioner underwent a CT scan to her right wrist related to complaints of right wrist pain. (PX 3)

On February 10, 2010, Petitioner began seeing Dr. Lawrence Li. Dr. Li's records include the following history:

> Mary Ann is a 68-year-old female who has a ten-year history of numbness and tingling in both her hands. She worked as a secretary for approximately 30 years at the St. Mary's Hospital in Streator and about ten years ago, she developed numbness and tingling, was dropping objects, and felt clumsy. Over this time, she has verbally told the people at St. Mary's that she had this problem and thought it was work related but never filed a worker's compensation claim because of fear that she would get terminated. (PX 5)

Dr. Li diagnosed the Petitioner with bilateral carpal tunnel syndrome. However, after EMGs were performed, Dr. Li concluded that the Petitioner did not have bilateral carpal tunnel syndrome, but he concluded that based on the EMGs, the Petitioner had left cubital tunnel syndrome. (PX 5.) Dr. Li also authored a report dated August 30, 2010 in which he stated that the Petitioner "worked as a secretary for approximately 30 years at St. Mary's Hospital in Streator, and she had symptoms of left cubital tunnel for over 10 years." (PX 2.)

The Petitioner eventually underwent left cubital tunnel release and anterior transposition of the ulnar nerve from

Dr. Li from September 27, 2010. (PX 7.)

Dr. Li testified by evidence deposition on November 21, 2011. He reviewed the Petitioner's job duties and opined that there is a causal relationship between the Petitioner's job duties and her condition of ill-being. (PX 1, pp.19-20) Dr. Li stated the Petitioner's job duties of filing, typing and using her hands all day long for 30 years contributed to her cubital tunnel syndrome.

The Petitioner was eventually released from all medical care, and she testified that she has no future follow-ups scheduled with any physician or surgeon. Both the Respondent and the Petitioner introduced a memorandum dated February 15, 2008 which was a "job description" that was actually prepared by the Petitioner on that date. (PX 9; RX 3.) The Respondent also offered a "job description" for Mary Ann Woodward, secretary, which was also prepared by the Petitioner and dated January 13, 2009. (RX 2)

The Petitioner testified that following her work with St. Mary's Hospital, she worked on a limited basis at a tax service. She is currently not working and has essentially retired.

The Respondent had an analysis performed by Jay Pomerance, M.D., pursuant to Section 12 of the Illinois Workers' Compensation Act. (RX 1) Dr. Pomerance testified via evidence deposition on May 25, 2012. Dr. Pomerance testified that the Petitioner did have a ten-year history of numbness and tingling in both hands and complained that she could not feel her fingers. He noted that the treating physician initially gave the Petitioner a diagnosis of carpal tunnel syndrome, but because the nerve conduction testing did not show any abnormalities consistent with carpal tunnel syndrome, the diagnosis was changed to cubital tunnel syndrome on the left (ulnar neuropathy). (RX 1, p. 11.) Dr. Pomerance concluded that the Petitioner's left cubital tunnel syndrome was not related to her work duties and referenced the majority of cases where this condition was found to be idiopathic in nature. (RX 1, p. 12.) Dr. Pomerance stated that if there is direct pressure on the ulnar nerve for prolonged periods of time, then this type of activity could cause cubital tunnel syndrome. (RX 1, p. 13.) Finally, Dr. Pomerance opined that people can get cubital tunnel symptoms from fixed-flexed posturing of the elbow past about 110 to 120 degrees. (RX 1, p. 14.) He also noted that there can be a condition known as ulnar nerve instability, which can cause cubital tunnel syndrome - a condition that is present, based on current research, in anywhere from 17 to up to 33 percent of the population. (RX 1, pp. 14-15.)

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. In support of this finding the Arbitrator relies on the Petitioner's testimony and the medical evidence, which all present some sort of contradiction. As noted at the beginning of the hearing, the Petitioner alleged an injury to her right hand in her Application for Adjustment of Claim. This allegation was not changed, despite the parties having a discussion at the beginning of the hearing to amend the Application. It was quite surprising to then receive evidence of Petitioner's complaints to her left hand. But even putting this blatant clerical error aside, the Petitioner's testimony and medical evidence still presented insurmountable issues of credibility. As a primary example, Petitioner testified that she was having problems with her hands while she performed her numerous, varied job duties. Yet the Petitioner did not seek any medical treatment for these problems while she was working for Respondent, despite the fact that she had previously undergone surgery for pain in her thumbs due to complaints of pain and arthritis. According to Dr. Li – who relied on Petitioner's history to formulate his opinions – Petitioner told people at her employer about her problems. However Petitioner then testified that she did not report her problems because she feared she would lose her job. Petitioner's credibility is further called into question when she described her duties required her to type for 4 hours, handle dictation for 2 hours,

16IWCC0400

answer the phone for 2 hours, make photocopies for 1 hour, do surveys for 1 hour and also send out 700 to 1200 patient surveys. This testimony, when taken as a whole, makes it seem like Petitioner worked over 10 hour days – which the Arbitrator finds incredible. It is more likely that the Petitioner's job duties were varied throughout the day. And even more incredible is Petitioner's claim that her hand problems became intolerable after she stopped working for Respondent – when presumably, she stopped all of her alleged repetitive hand activity. Based on these factors – i.e. the lack of credibility and the Petitioner's varied work duties throughout the day - the Arbitrator concludes that the Petitioner failed to prove that she sustained an accident on January 12, 2010.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner failed to meet her burden of proof. This finding is supported by the medical evidence coupled with the Arbitrator's findings above on the question of Petitioner's credibility. The lack of credibility underlying this claim is further increased when looking to the medical evidence. Petitioner's initial medical records indicate a diagnosis of bilateral carpal tunnel syndrome. Dr. Li's testimony appears to indicate that the Petitioner's hand complaints may have been due to thenar atrophy, resulting from her CMC arthroplasty for her thumbs, which Dr. Li does not causally relate to Petitioner's employment. To make matters more confusing, Dr. Li also testified with regard to Petitioner's complaints of right arm pain from a variety of sources, which Dr. Li did not believe was relevant to her cubital tunnel condition. (See PX, p. 13) Dr. Li then changed the Petitioner's diagnosis to left cubital tunnel syndrome following the results of an EMG. He opined that the the cubital tunnel syndrome was work related based on the job description provided by Petitioner. However, the strength of that opinion is undermined when looking at the evidence as a whole. Dr. Li relied on a job description that made Petitioner appear to be typing, lifting, filing and having her arm bent at 90 degrees or more for 8 hours every day. As indicated above, the Petitioner's job duties were more likely than not varied throughout the day. As such, the Arbitrator is not persuaded by Dr. Li's opinions on causation. The Arbitrator finds persuasive Dr. Pomerance's opinions on this issue, and concludes that the Petitioner failed to prove her condition of ill being is causally related to her employment.

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

STATE OF ILLINOIS)
) SS.
COUNTY OF)
MCHENRY

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Green,

Petitioner,

16IWCC0401

vs.

NO: 13 WC 42006

Centegra Health Systems,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection and prospective medical care and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Commission finds that the Petitioner failed to prove that she sustained repetitive trauma injuries to her right wrist arising out of her employment as a pharmacy technician on December 13, 2013. Petitioner was 52-years-old on the alleged date of accident and is right-hand dominant. It is undisputed that Petitioner has a congenital abnormality of the forearm and wrist known as positive ulnar variance; her ulna is disproportionately longer than her radius. It is furthermore undisputed that positive ulnar variance is a risk factor for a chronic and degenerative inflammatory condition known as ulnar abutment syndrome or ulnar impaction syndrome. Petitioner testified that she had no problems or complaints regarding her right wrist until November of 2010.

From 2008 to 2011, Petitioner worked as a part-time pharmacy technician for Respondent's hospital in Woodstock. In November of 2010, Petitioner fell on her right wrist while walking her dog. Immediately after the injury, Petitioner began having pain in her right wrist. She testified that she sought treatment with her primary care physician and was referred to Dr. Holtkamp, an orthopedic surgeon specializing in hand surgery. Dr. Holtkamp examined Petitioner on November 15, 2010 and diagnosed Petitioner with right wrist ulnar abutment syndrome. Dr. Holtkamp administered a cortisone injection and provided Petitioner with a wrist

brace. She advised that an arthroscopy with ulnar shortening osteotomy would be the recommended treatment if cortisone injections failed to relieve Petitioner's symptoms.

Petitioner testified that sometime in 2011 she began working full-time and transferred to Respondent's McHenry hospital. On November 21, 2011 Petitioner returned to Dr. Holtkamp for another cortisone injection. She reported increased symptoms with no specific occurrence. Petitioner returned to Dr. Holtkamp a third time on June 28, 2012. Petitioner again reported that her symptoms had returned. Dr. Holtkamp performed another cortisone injection and fitted Petitioner for a new brace. She advised Petitioner that the next step would be an MRI "to further evaluate the ligaments and more likely than not [Petitioner] would require shortening osteotomy." Petitioner did not return to Dr. Holtkamp again for approximately one and a half years.

On December 14, 2013, Petitioner presented to the emergency room at Centegra Hospital. She gave a history of "doing the same activities at work for three days resulting in severe pain in her wrist." Petitioner was noted to have a history of treatment for chronic inflammatory pain. She was issued work restrictions for limited use of the right hand. On December 19, 2013 Petitioner was examined by Dr. Holtkamp, who noted that Petitioner had been in the emergency room for a flare-up of ulnar abutment syndrome on December 13, 2013. Dr. Holtkamp further noted that Petitioner's pain seemed to be localizing directly over the triangular fibrocartilage complex ("TFCC"). Petitioner explained to Dr. Holtkamp that her pain is most severe while "drawing up" medications in syringes, which Petitioner reported doing 60 to100 times per day. Dr. Holtkamp again discussed surgical treatment for ulnar shortening and explained that Petitioner's triangular fibrocartilage complex ("TFCC") would be assessed due to signs of a potential peripheral tear. Dr. Holtkamp opined that Petitioner's right wrist pain was causally related to work "secondary to aggravating a preexisting problem due to the repetitive nature of her job."

Petitioner filed an Application for Adjustment of Claim with the Commission on December 23, 2013. Respondent subsequently had Petitioner examined by Dr. Vender pursuant to §12. On April 10, 2014, Dr. Vender issued a report wherein he agreed with Dr. Holtkamp's diagnosis of ulnar impaction syndrome and the recommendation for ulnar shortening surgery. However, Dr. Vender did not agree that Petitioner's condition is causally related to her employment. Dr. Vender found no evidence to support the conclusion that Petitioner's normal work activities accelerated the natural progression of her degenerative condition.

On June 2, 2014, Dr. Holtkamp issued a narrative report restating the opinion she stated in her office note of December 19, 2013. Dr. Holtkamp opined that within a reasonable degree of medical certainty Petitioner's ulnar abutment syndrome was aggravated by repetitive job duties. Dr. Holtkamp again mentioned that Petitioner filled syringes 60 to 100 times per day. Dr. Holtkamp opined that Petitioner failed conservative treatment and surgery was recommended for definitive treatment. Petitioner returned to Dr. Holtkamp on September 4, 2014 for a reexamination. She reported increased pain preparing IV bags at work. Dr. Holtkamp also noted that Petitioner moved from part-time to full-time "last summer" and consequently the frequency of the task of filling IV bags increased. Dr. Holtkamp issued additional work restrictions against IV bag preparation and again recommended surgery.

Dr. Holtkamp testified via deposition on September 11, 2014. Dr. Holtkamp agreed that Petitioner initially sought treatment for right wrist pain brought on by a fall. At the time of her first examination, Petitioner did not complain of any problems performing her work duties. She testified that her November 2013 causal connection opinion came about after detailed conversations with Petitioner and reviewing a job description. Dr. Holtkamp was shown written job descriptions from Centegra Health for pharmacy technician positions; she agreed that the activities listed are consistent with Petitioner's own description of her work duties. Dr. Holtkamp testified that performing these job duties aggravated Petitioner's preexisting condition and caused the need for surgery. Dr. Holtkamp also reviewed Dr. Vender's §12 report and testified that she disagreed with Dr. Vender's opinion on causal connection. She reasoned "something has to be aggravating [Petitioner's] condition for her to continue to have this pain that will not resolve with a cortisone injection." Dr. Holtkamp testified that Petitioner's work restrictions were intended to limit the activities Petitioner complained of difficulty performing. She testified that she is personally familiar with the task of filling syringes and believes that it can be strenuous. However, Dr. Holtkamp admitted that she had no knowledge of Petitioner's activities outside of work and she agreed that activities outside of work could also produce symptoms.

Dr. Holtkamp further suspected that Petitioner eventually developed a peripheral TFCC tear as a result of continued repetitive work duties. Dr. Holtkamp believed that there was no evidence a TFCC had been present since the time of Petitioner's fall in 2010. She testified that subsequent to her fall, Petitioner's symptoms were consistent with "straightforward ulnar abutment syndrome." However, when Petitioner returned in 2013 she had new symptoms of clicking and popping and furthermore she reported to the emergency room for severe pain after performing the same activities for three days. Dr. Holtkamp opined that Petitioner's work duties aggravated her underlying condition and ultimately caused the suspected TFCC tear.

Dr. Vender testified via deposition on September 22, 2014. Dr. Vender is an orthopedic surgeon specializing in hand surgery. He testified that his opinion was unchanged from his §12 report; Dr. Vender opined that Petitioner's current condition of ill-being is unrelated to her employment. He denied that Petitioner's work activities could place enough stress on the wrist area to cause "a real injury." He opined that the underlying condition has its "natural course" irrespective of activity. He agreed that symptoms may be temporarily aggravated. Dr. Vender testified that if a TFCC tear is in fact confirmed via arthroscopy, the cause would be progression of degenerative disease and not work activities. Dr. Vender testified that although he examined Petitioner on only one occasion, the cause of Petitioner's condition was clear from her history, treatment and examination.

Petitioner testified that she performed the same types of work duties throughout her employment by Respondent as a pharmacy technician, but that she had no right wrist problems until after the 2010 fall. Petitioner testified that beginning in 2011 she relocated to the McHenry campus of Centegra Hospital from the Woodstock campus. We note that is inconsistent with Dr. Holtkamp's record of September 4, 2014 that Petitioner began full-time work in "last summer." Petitioner testified that the McHenry hospital was larger and busier than the Woodstock hospital and consequently her work duties increased, especially with respect to mixing and pulling and pushing medications through syringes in the cancer center. She testified that she worked in the

cancer center in addition to the main pharmacy and that she was one of several employees specifically trained to mix chemotherapy medications within a ventilation hood in the cancer center. She testified that the work preparing chemotherapy medications could be "nonstop" and that she rarely got a break from mixing one compound after another due to the high demand.

Petitioner testified that she started each day delivering boxes of pre-mixed compounds. The boxes, which she loaded onto a cart for delivery, weighed twenty-eight pounds each. Petitioner pushed the cart to deliver the boxes to various floors, opening the boxes and placing the compounds in the medication-dispensing machines. She testified that this work took about an hour to perform. Petitioner testified that she would then work in the cancer center or main pharmacy, mixing medications to fill orders using syringes of various sizes.

Petitioner testified that on December 13, 2013 the pain in her right wrist was extreme and caused her to seek treatment at the emergency room. Petitioner agreed that there was no specific incident that correlated with her increased pain; she testified that her symptoms culminated over time. She testified that working in the cancer center pharmacy was what "broke the camel's back." We note that there is no accident report or supervisor's statement in the record.

A current coworker of Petitioner's, Mr. Uselton, testified for Respondent. Mr. Uselton is a pharmacy technician employed by Respondent for thirteen years. He worked in the cancer center as well as the main pharmacy. He testified that specially-trained employees rotate between the cancer center and the main pharmacy. He therefore did not work in the cancer center at the same time as Petitioner because they rotated. However, he testified that he believed that he and Petitioner performed all of the same duties. Mr. Uselton estimated that fewer boxes, and of lesser weight, were delivered around the hospital on a daily basis. He further estimated that each delivery took no longer than thirty minutes. In Mr. Uselton's experience, there were fewer medication orders needing to be prepared on an average day than Petitioner alleged. Otherwise, Mr. Uselton corroborated Petitioner's testimony with respect to the various job duties performed by pharmacy technicians. Mr. Uselton did not testify with respect to any knowledge of Petitioner's complaints or report of injury; he testified that he was aware that Petitioner was no longer performing her regular job duties.

Petitioner testified that she is now working as a "med rec technician" for Respondent, interacting with patients and managing prescriptions between pharmacies and doctors' offices. Petitioner testified that she no longer fills syringes or IV bags pursuant to her restrictions. She testified that she does not know whether her restrictions will be permanently accommodated by Respondent. Petitioner further testified that outside of work she is very careful about what she does with her right wrist. She testified that her symptoms essentially resolved with her change in activity, and she denied any complaints or problems with her right wrist currently. We note there is no indication in the depositions of either Dr. Holtkamp or Dr. Vender of whether they are aware that Petitioner's symptoms have essentially resolved.

After considering all of the evidence, we conclude that Petitioner experienced a temporary aggravation of the symptoms of her chronic condition of ulnar abutment syndrome; her symptoms have currently abated with activity modification. We find that Petitioner failed to prove a compensable repetitive trauma injury manifesting on December 13, 2013. Accordingly,

we find that the need for surgery is not causally related to Petitioner's employment, but to her non-occupational chronic condition, and therefore we hereby reverse the decision of the arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated July 1, 2015 is hereby reversed and remanded.

The party commencing 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: JUN 15 2016
RWW/plv
o-04/27/16
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

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

GUILLERMO RODRIGUEZ,

Petitioner,

16IWCC0402

vs.

NO: 09 WC 48801

ROTA TIRES & STATE TREATURER AS *EX OFFICIO*
CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND,

Respondents.

DECISION AND OPINION ON REVIEW

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

In the final bullet-point paragraph in the "Order" section of the decision, the Arbitrator includes the language indicating that Petitioner is eligible for cost-of-living benefits under the Rate Adjustment Fund ("RAF") commencing on the second July 15th after entry of the award. Claimants, or their qualified dependents, are eligible for RAF benefits only based on a decision finding the injured worker permanently and totally disabled or that the claimant died from work-related causes, respectively. No such finding was made in this decision and therefore RAF benefits are not applicable. Accordingly, the Commission deletes the final bullet-point paragraph in the "Order" section in the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 22, 2015 is hereby changed as specified above and otherwise affirmed and adopted.

16IWCC0402

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Bond for removal of this cause to the Circuit Court by Respondent, Rota Tires, is hereby fixed at the sum of $21,500.00. Bond for removal of this cause to the Circuit Court by Respondent, Injured Workers' Benefit Fund, is hereby fixed at the sum of $11,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 15 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-5/25/16
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0402

RODRIGUEZ, GUILLERMO
Employee/Petitioner

Case# 09WC048801

ROTA TIRES AND ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 4/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0247 HANNIGAN & BOTHA, LTD
PATRICK CZUPRYNSKI
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

0000 ROTA TIRES
1244 S CICERO AVE
CICERO, IL 60804

5273 ASSISTANT ATTORNEY GENERAL
MEGAN MURPHY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

GUILLERMO RODRIGUEZ
Employee/Petitioner

Case #09 WC 48801

v.

ROTA TIRES AND ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on March 27, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☒ Was there an employee-employer relationship?

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

D. ☒ What was the date of the accident?

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

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

G. ☒ What were the petitioner's earnings?

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

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

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

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

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

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

N. ☒ Is the respondent due any credit?

O. ☒ Prospective medical care?

FINDINGS

- This claim was on file for more than three years when it appeared on the March 9, 2015, status call and received a trial date of March 27, 2015. Respondent Rota Tires failed to appear by its officers or a representative at the status call or trial date. The petitioner presented evidence on the trial date of a notice on March 10, 2015, of this hearing date, time and location to respondent Rota Tires at their last known address via regular and certified U.S. Mail and moved to proceed *ex parte* against them.

- The petitioner received a certification of no workers' compensation insurance coverage for respondent Rota Tires for the claim date of October 13, 2009. The petitioner amended his Application to seek benefits from the Injured Workers' Benefit Fund pursuant to §4(d) of the Act.

- The respondent Injured Workers' Benefit Fund Illinois through the State Treasurer, the *ex-officio* custodian of the Injured Workers' Benefit Fund, was represented by the Illinois Attorney General's office.

- Respondent Rota Tires did not appear or request a continuance and a hearing was conducted *ex parte* against them.

ORDER:

- The respondent Rota Tires shall pay the petitioner temporary total disability benefits of $233.33/week for 25-5/7 weeks, from October 19, 2009, through April 16, 2010, which is the period of temporary total disability for which compensation is payable.

- The petitioner's request for temporary partial disability benefits is denied.

- The respondent shall pay the petitioner the sum of $213.33/week for a further period of 25 weeks, as provided in Section 8(d)2 of the Act, because the injury sustained to his right shoulder caused the permanent partial disability to petitioner to the extent of 5% of a man.

- The respondent Rota Tires shall pay the petitioner $10,000.00 in penalties pursuant to Section 19(l) of the Act.

- The respondent Rota Tires shall pay the petitioner compensation that has accrued from October 13, 2009, through March 27, 2015, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for his right shoulder was reasonable and necessary and is awarded. The respondent Rota Tires shall pay the medical bills in accordance with the Act and the medical fee schedule and shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- Except for penalties, an award is hereby entered against the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of respondent Rota Tires to pay the benefits due and owing the petitioner. The respondent Rota Tires shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of respondent-employer that are paid to the petitioner from the Injured Workers' Benefit Fund.

- Commencing on the second July 15th after the entry of this award, the petitioner may become eligible for cost-of-living adjustments paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

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

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

Robert E. Williams

Signature of Arbitrator

April 21, 2015

Date

APR 22 2015

FINDINGS OF FACTS:

On October 19, 2009, the petitioner, a laborer, sought medical treatment at Lawndale Christian Health Center for right shoulder pain after lifting a heavy object at work four weeks earlier. An x-ray of his right shoulder was reported to be negative for fractures. He was prescribed Ibuprofen and Flexeril. The petitioner began treatment with chiropractor David Krueger at Physicians Plus Ltd on November 18th and reported constant stabbing sharp right shoulder pain. He reported that his injury began on October 13, 2009, while lifting a tire rim. X-rays of his right shoulder were negative for fractures and soft tissue structures were unremarkable. Dr. Krueger gave the petitioner lifting and overhead work restrictions. He reported continued right shoulder pain on the 18th and the 19th. Dr. Huddleston saw the petitioner on the 20th and opined that the petitioner's right shoulder was due to rotator cuff tendinopathy. On December 4th, Dr. Huddleston noted that the petitioner was improving and that an MRI on December 1st revealed right supraspinatus tendinitis. Less soreness was noted with overhead lifting on December 9th. Dr. Huddleston gave the petitioner a Depo-Medrol injection on December 18th.

On January 26, 2010, Dr. O'Keefe saw the petitioner. The petitioner reported a work injury on October 13, 2009, receiving medical care the same day and told not to work for five days but made to continue his work duties by respondent for 3 to four days with 40-50 pound loads until his termination on October 19, 2009. An EMG/NCV on January 29, 2010, revealed a neuropathy at C5-T1 on the right. The petitioner received chiropractic modalities several times per week until his discharge on April 16, 2010. Dr. Krueger recommended permanent restrictions of 50 pounds and part-time work.

FINDING REGARDING WHETHER RESPONDENT ROTA TIRES WAS OPERATING UNDER AND SUBJECT TO THE WORKERS' COMPENSATION ACT:

Based upon the evidence presented, the respondent Rota Tires was operating under and subject to the provision of Section 3, paragraph 15 of the Workers' Compensation Act. The respondent Rota Tires engaged in a business in which electric, gasoline or other power-driven equipment was used in their operation.

FINDING REGARDING WHETHER THERE WAS AN EMPLOYER/EMPLOYEE RELATIONSHIP BETWEEN THE PETITIONER AND RESPONDENT ROTA TIRES:

An employer/employee relationship existed between the petitioner and the respondent Rota Tires on October 13, 2009.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT ROTA TIRES:

Based upon the testimony and the evidence submitted, the petitioner proved that he sustained an accident on October 13, 2009, arising out of and in the course of his employment with the respondent Rota Tires. The petitioner has given various versions of how his injury occurred and has indicated an accident date before October 13, 2009. On October 19, 2009, the date he was terminated by the respondent, the petitioner sought his initial medical care at Lawndale Christian Health Center and reported right shoulder pain due to lifting that occurred about four weeks earlier. When he started care with Dr. Krueger he reported that he injured his right shoulder lifting a tire rim on October 13, 2009. The petitioner reported to Dr. O'Keefe that he stopped a tire rim from falling using his right arm and that he reduced his shoulder by smashing it into a wall. The petitioner testified that he was lifting a wet, slippery rim onto a machine that did not catch and stretched his hand. While the many versions and discrepancies in the descriptions of his

injury are alarming, the petitioner has consistently attributed lifting while working as the primary cause of his right shoulder injury.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT ROTA TIRES:

Based upon the testimony and the evidence submitted, the respondent Rota Tires received timely notice of the petitioner's injury.

FINDING REGARDING THE AMOUNT OF WAGES, MARITAL STATUS AND DEPENDENTS:

Based upon the testimony and the evidence submitted, in the year preceding the injury, the petitioner's average weekly wage from respondent Rota Tires was $350.00 per week. At the time of injury, the petitioner was 35 years of age, single with no children under 18 years.

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

The medical care rendered the petitioner for his right shoulder was reasonable and necessary. The respondent Rota Tires shall pay the medical bills in accordance with the Act and the medical fee schedule.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his right shoulder is causally related to the work injury on October 13, 2009.

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

The petitioner was temporarily totally disabled from October 19, 2009, through April 16, 2010. The respondent Rota Tires shall pay the petitioner temporary total

disability benefits of $233.33/week for 25-5/7 weeks, from October 19, 2009, through April 16, 2010, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

The petitioner failed to prove that he is entitled to temporary partial disability after April 16, 2010. His testimony that he earns approximately $250.00 per week doing mechanical work is not sufficient to establish his current earning capacity. The petitioner's request for temporary partial disability is denied.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner complains of right arm pain, numbness and reduced strength and motion. The respondent shall pay the petitioner the sum of $213.33/week for a further period of 25 weeks, as provided in Section 8(d)2 of the Act, because the injury sustained to his right shoulder caused the permanent partial disability to petitioner to the extent of 5% of a man.

FINDING REGARDING PENALTIES AND FEES:

The respondent Rota Tires shall pay the petitioner $10,000.00 in penalties pursuant to Section 19(l) of the Act. The petitioner's request for Section 19(k) penalties and Section 16 fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jason Utley,

Petitioner,

16IWCC0403

vs.

NO: 15 WC 2324

Vonachen Services, 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 accident, medical expenses, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 December 4, 2015, is hereby affirmed and adopted.

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

16IWCC0403

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 $1,200.00. 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: JUN 15 2016
o6/7/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0403

UTLEY, JASON
Employee/Petitioner

Case# **15WC002324**

VONACHEN SERVICES INC
Employer/Respondent

On 12/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0225 GOLDFINE & BOWLES PC
KEVIN ELDER
4242N KNOXVILLE AVE
PEORIA, IL 61614

0264 HEYL ROYSTER VOELKER & ALLEN
CRAIG YOUNG
PO BOX 6199
PEORIA, IL 61601

16IWCC0403

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)

Jason Utley
Employee/Petitioner

v.

Vonachen Services, Inc.
Employer/Respondent

Case # **15** WC **2324**

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **October 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*** 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 $**4,023.00**; the average weekly wage was $**182.86**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **1** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**182.86**/week for **3 4/7** weeks, commencing **October 19, 2015** through **November 9, 2015**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $**462.93**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for reasonable and necessary medical services and post-surgical care prescribed by Dr. DeBord, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

December 1, 2015
Date

DEC 4 - 2015

FACTS:

On October 27, 2014, the Petitioner was employed by the Respondent as a janitor, having been so employed since June of 2014. The Petitioner's job duties included lifting chairs, moving furniture, mopping, and carrying buckets of water. The Petitioner testified that his main job assignment was maintenance at a restaurant called the Lariat Club, where he worked six days a week for four hours each morning. The Petitioner testified that on Sunday, October 26, 2014 the wood floors at the Lariat Club were refinished and that his job duties the following morning included moving the furniture, chairs and hostess podium back into place on the wood floor, from the carpeted floor where they had been set. The Petitioner described that the hostess podium is solid wood, approximately four feet tall and three feet wide and holds stacks of menus inside of it. It has four wheels for rolling. All three witnesses who are familiar with the podium concurred that it is "very heavy", weighing between one hundred and two hundred pounds. The podium is depicted in Petitioner's Exhibit 6 and Respondent's Exhibit 4.

The Petitioner testified that later in his shift on October 27, 2014, he moved the hostess podium through a narrow doorway onto the wood floor. He testified that the seam between the carpeting and wood was not level and required some lifting and "momentum" to carefully get the podium wheels onto the newly re-surfaced wood floor. He testified that he lifted with both arms at slightly below shoulder level on each side in order to get it over the transition from the carpeting to the wood floor and that, as he lifted and pushed, he felt a "twinge" and some pain in his abdominal area. The Petitioner testified that he did not report this incident to anyone that day.

The Petitioner testified that over the next few weeks, he began to develop increasing pain and a "bulge" in his abdominal area. He testified that he told his girlfriend Amy Taylor about the injury and the bulge and that she encouraged him to seek medical treatment.

Amy Taylor, the Petitioner's girlfriend testified that sometime shortly after October 27, 2014 the Petitioner told her that he had hurt himself at work moving a podium. Ms. Taylor testified that while the Petitioner lived with her in an apartment at this time, they had not changed their residence, or moved any heavy furniture. Ms. Taylor testified that the Petitioner did not hurt his groin helping her with any cleaning or lifting in the apartment.

On November 25, 2014, the Petitioner sought medical attention at the Unity Point Health Prompt Care in Morton, Illinois. The history noted there was, "...he had to lift a heavy object about 3 weeks ago by himself; he noticed some mild discomfort immediately then he noticed bulging in the groin a few days later...He informs me that he had not had any pain or bulging in this area prior to this incident at work". The Petitioner was diagnosed with bilateral direct reducible inguinal hernias, was referred to a general surgeon, and was given a lifting restriction.

The Petitioner testified that he brought his restriction to work the following day and met with his supervisor, Kim Cleveland. He testified that, at that time, he reported his October 27, 2014 work accident and filled out a written report. The accident report was admitted into the record as Respondent's Exhibit 1 and indicates that the Petitioner reported that he "...was helping Lariat staff move podium...moved podium from one room to another, was extremely heavy..." He also reported that he "Didn't realize severity of injury until started seeing swelling..."

On November 26, 2014, the Petitioner was sent by Respondent to OSF Occupational Health, where he saw Dr. Daniel Braun. The history noted was that on October 27, 2014 he assisted a Lariat employee with moving a heavy podium. As he walked with the podium, he noted burning and pain in his groin area. He thought the pain would go away, but over the next few weeks, the pain persisted and he noticed a bulge in his groin while in the shower. Dr. Braun diagnosed the Petitioner as having bilateral inguinal hernias and gave him a 20 pound lifting restriction. Dr. Braun recommended that the Petitioner follow-up with a surgeon. Dr. Braun added, "...I do feel it is possible that he could develop a bilateral hernia with an instance of lifting as described on October 27th. There is no obvious history of previous hernia or activities which would cause a hernia."

The Respondent accommodated the Petitioner's restrictions until the Petitioner quit for unrelated reasons in September 2015.

On December 1, 2014 the Petitioner saw Dr. Brian Haywood. The history noted at that time was, "Patient states that while at work on October 27, 2014 he was lifting and pulling when he felt a sudden pulling sensation in his right groin. This then turned into pain. Later he noticed swelling and enlargement of his left groin." Dr. Haywood diagnosed the Petitioner as having a bilateral inguinal hernia, reducible, and he recommended surgery for the Petitioner.

On December 5, 2014, the Petitioner followed-up with his primary care physician, Dr. Hensold and the history noted that day was of a "work related injury in October with a strain causing bilateral inguinal hernias" and "...awaiting work comp approval to proceed with surgery". Dr. Hensold recommended surgical repair as soon as possible.

Kim Cleveland, the Respondent's Area Operations Manager testified that the Respondent's company policy requires immediate reporting of an injury and that the Petitioner was aware of the polkicy. Ms. Cleveland testified that she was first given notice of the Petitioner's claimed October 27, 2014 injury on November 26, 2014 and that she investigated the accident scene and took photos of the podium. On cross-examination, she admitted that the podium is "very heavy" and that the Lariat club's wood floors had been refinished on Sunday, October 26, 2014.

Samantha Rogers, the niece of Kim Cleveland, and a "lead" employee of the Respondent at the Lariat Club testified that sometime in September 2014, the Petitioner was on a break with her and told her that he had hurt his abdominal area while moving furniture with his girlfriend in their apartment. In his rebuttal testimony, the Petitioner denied telling Ms. Rogers that he had hurt himself at home, and denied that he had injured himself helping his girlfriend clean their apartment.

At the request of his attorney, the Petitioner was evaluated by Dr. Alexander Cummings on August 21, 2015. Dr. Cummings reviewed all of the medical records and diagnosed the Petitioner as having bilateral inguinal hernias. As to causal connection, Dr. Cummings opined, "...the information available indicated this patient had a discreet lifting straining injury and the symptoms began and he shortly thereafter was diagnosed with symptomatic bilateral inguinal hernias. Therefore, I would apportion all of his current condition to industrial causation, namely the lifting and straining injury that occurred at work on October 27, 2014."

On October 19, 2015, the Petitioner underwent surgery for repair of the bilateral inguinal hernias, by Dr. James DeBord. The Petitioner testified that he has a follow-up appointment scheduled with Dr. DeBord and that he has not yet been released from care.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, (E.), Was timely notice of the accident given to Respondent, and (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

With regard to the issue of accident, the Arbitrator notes that the history of accident the Petitioner provided to all of his medical providers and to the Respondent has been consistent and detailed. The only conflicting history is that testified to by Samantha Rogers, which is in direct conflict with both the Petitioner's testimony and the testimony of his girlfriend, Amy Taylor. The Arbitrator notes that Ms. Rogers admitted to having a "special interest" in stopping fraudulent workers' compensation claims and continues to work for the Respondent in a quasi-management role. Ms Rogers also acknowledged that Kim Cleveland, the Respondent's area operations manager, is her Aunt. The Arbitrator finds the Petitioner's testimony and that of Amy Taylor to be more credible and reliable than the testimony of Ms. Rogers. The greater weight of all of the documentary evidence, the accident report and the medical histories, supports the Petitioner's testimony as well. The Arbitrator accordingly finds that the Petitioner has established that a compensable accident occurred on October 27, 2014.

With regard to the issue of timely notice, there is essentially no dispute. Detailed, written notice of the accident was given to the Respondent on November 26, 2014, approximately 31 days post-accident. This is clearly timely notice under the Act.

With regard to the issue of causal connection, the Arbitrator notes that Dr. Braun, the Occupational Medicine doctor who saw the Petitioner at the Respondent's request, opined that the Petitioner's accident could have caused his condition, and opined further that there were no other known accidents or risk factors that could explain the injury.

The only other medical provider to render a causation opinion was Dr. Cummings who opined that the October 27, 2014 work accident was directly responsible for the Petitioner's bilateral inguinal hernias. Additionally, the Petitioner denied having any previous symptoms, other than kidney stones, which was a very different condition and symptom presentation than Petitioner's hernias, in September 2013. The Petitioner denied having any subsequent abdominal injuries as well. The Respondent presented no evidence of any pre-existing treatment or complaints, other than the testimony of Samantha Rogers. Also, the Respondent did not present a Section 12 independent medical opinion to rebut causal connection.

Based upon the above, the Arbitrator finds that Petitioner has established the requisite causal connection between his October 27, 2014 work accident and his current condition of ill-being.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, (K.), Is Petitioner entitled to any prospective medical care, and (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

Having found for the Petitioner on the issues of accident, notice and causal connection, it logically follows that the related medical treatment and expenses are properly awarded.

Petitioner's Exhibit 7 evidences a Medicaid lien for $174.93 from the Illinois Department of Healthcare and Human Services. The services paid for relate to treatment for an inguinal hernia on May 27, 2015 and June 4, 2015. This lien is awarded. The treatment on October 12, 2015 is not awarded as there is no evidence of what the treatment was for or whether it is related to a hernia. The medical treatment from Dr. Hensold on November 25, 2014 ($96.00), December 5, 2014 ($96.00), and on February 23, 2015 ($96.00) are all three clearly related to the Petitioner bilateral hernias (Petitioner Exhibit 4) and are awarded. The total amount of medical expenses awarded is $462.93.

The Petitioner's surgery on October 19, 2015 is found to be reasonable, necessary and causally related and the bills of Dr. DeBord and the surgical facility, as well as the post-operative care, are found to be reasonable, necessary and causally related and are awarded.

The Petitioner is also awarded Temporary Total Disability benefits from the date of his surgery on October 19, 2015 through the date of Arbitration on November 9, 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 KANE)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rocio Perez,

Petitioner,

vs. No. 07 WC 40315

Wendy's,

16IWCC0404

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court. The circuit court remanded the matter to the Commission with directions to determine the dollar amount of recoverable medical expenses related to Petitioner's left lateral meniscal tear. This is the sole issue on remand.

The record shows that Petitioner testified all medical bills had been paid by Cigna, the medical insurance carrier through the employer of her then husband, or paid out of pocket. The parties entered into a stipulation on April 4, 2011, that the fee schedule amounts of the medical bills total $37,767.32. However, Respondent disputed the fee schedule is the appropriate basis for determining the award of medical expenses. Rather, Respondent argued the award of medical expenses should be based on the amounts paid by Cigna, plus the amounts Petitioner paid out of pocket. Respondent introduced into evidence a record of payments made by Cigna, showing payments of $17,597.96 and deductibles/copays of $260.00. On remand, Petitioner seeks an award of $37,767.32, while Respondent argues such an award would amount to a windfall. Respondent maintains its liability is limited to $17,857.96, the amount that relieves Petitioner of the costs or her medical care.

Section 8(a) of the Workers' Compensation Act (the Act) provides, in pertinent part: "The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered for all the necessary first aid, medical and surgical services,

and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury." 820 ILCS 305/8(a). The plain language of the statute limits the employer's liability to "the negotiated rate, if applicable." The statute does not require the employer to be a party to the rate agreement in order to receive the benefit of the agreement. The Commission finds Petitioner's interpretation of the statute is inconsistent with the legislative intent to mitigate the costs to the employers of providing reasonable and necessary medical care for work-related injuries. See Tower Automotive v. Workers' Compensation Comm'n, 407 Ill. App. 3d 427, 438 (2011) (the purpose of the Act is satisfied when the employee is relieved of the costs of reasonable and necessary medical care).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $17,857.96 for medical expenses under §8(a) of the Act. In the event this amount proves insufficient to relieve Petitioner of the costs of her medical care related to the work accident, Respondent shall hold Petitioner harmless from any such claims and demands.

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 injuries.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,000.00. 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: JUN 16 2016
d-05/19/2016
SM/sk
44

Stephen J. Mathis

Mario Basurto

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edward T. Emery,

Petitioner,

vs.

No. 10 WC 45050

16IWCC0405

Michael J. Navilio & Son, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of causal connection, medical expenses, temporary disability, permanent disability, penalties and attorney fees, and being advised of the facts and law, corrects and modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner testified that he worked for Respondent full-duty as a loader and unloader of produce. His job duties were "[t]o load and unload trucks and to stack boxes on pallets, to check quality of merchandise and organize different pieces of produce." The job required heavy lifting, up to 125 pounds. On April 7, 2010, Petitioner suffered a twisting injury to the right knee when he stepped on a pallet and it broke. This injury is subject of companion case No. 10 WC 45051. Petitioner treated for the right knee injury with Dr. Michael Collins at Hinsdale Orthopaedics. The medical records show that Petitioner had intermittently treated with Dr. Collins for problems with the right knee since 1994. In January of 2006, Dr. Collins performed an arthroscopy of the right knee, noting "grade 3 chondromalacia of the patella with some unstable flap tears *** more towards the medial than the lateral side." Following the accident on April 7, 2010, Dr. Collins operated on the right knee on April 30, 2010. Dr. Collins performed an arthroscopic chondroplasty of the medial condyle and patella. No meniscal tear was identified. Dr. Collins

released Petitioner to return to work full duty on May 24, 2010. Petitioner testified that he returned to full-duty work for Respondent on or about June 8, 2010. Petitioner did not seek further treatment with Dr. Collins until he suffered a subsequent accident on November 15, 2010, which is subject of the instant claim.

Petitioner testified that on November 15, 2010, he was still working full-duty for Respondent. Petitioner was injured when the forklift he was riding was struck by another forklift. The impact caused him to be thrown from the forklift. Petitioner stated he landed on his buttocks and back and also felt the right knee twist. Petitioner admitted previously sustaining a low back injury in February of 2004 while working as a loader/unloader for a company called JAB Produce. Petitioner stated he underwent a "four-level" fusion in 2005. Petitioner further testified that he rehabilitated himself to be able to work full-duty by exercising for several hours a day. However, after he began working for Respondent, Petitioner sought pain management for his back symptoms. Petitioner worked full-duty while he received pain management.

The medical records in evidence show that following the work accident in 2004, Petitioner treated with Dr. Mark Lorenz at Hinsdale Orthopaedics. In February of 2005, Dr. Lorenz performed a fusion surgery from L3 through S1. During postoperative follow-up, Petitioner complained of debilitating back pain, as well as significant symptoms in the knees, the right worse than the left. In March of 2005, Dr. Lorenz referred Petitioner to Dr. Eugene Lipov for pain management, noting that Petitioner needed to be weaned off Dilaudid. In June of 2006, Dr. Lorenz performed a hardware removal surgery. In August of 2006, Dr. Lorenz noted that Petitioner underwent a detox program for dependency on narcotic pain medication. A functional capacity evaluation performed in October of 2006 placed Petitioner at the light to medium physical demand level, whereas his job as a loader/unloader of produce was at the heavy physical demand level. After reviewing the results of the functional capacity evaluation, Dr. Lorenz imposed permanent restrictions of maximum lifting of 36 pounds occasionally and no frequent bending. Dr. Lorenz recommended vocational rehabilitation and continuing pain management with Dr. Lipov.

In June of 2007, Petitioner returned to Dr. Lorenz, reporting that he finished pain management with Dr. Lipov and was "successful in vocational rehab." Dr. Lorenz noted: "He is doing much better. He is off *** narcotics. He is taking no medication. He has been exercising and weight lifting. He has gotten stronger; he still has some discomfort in his back, which he rates about 3 on the average. When he has a bad day it is up to 7. His definition of bad day is after he has been sitting all day with infrequent breaks. He rates his back pain is about 7/10. He has difficulty getting up and standing. He is very stiff. Also after sitting for prolonged days during vocational rehab, he has tingling in his foot." Physical examination was benign. Dr. Lorenz added the restriction of no sitting more than 60 minutes at a time and taking 15 minute breaks before returning to sitting, and instructed Petitioner to follow up as needed. In his testimony, Petitioner confirmed that he underwent a detox program to get off narcotic medication.

Petitioner further testified that he could not return to his job with JAB Produce because of the restrictions. For a period of time, Petitioner was in the business of "flipping" residential and commercial properties and/or working as a cook at a pizza restaurant. In January of 2009, Petitioner settled his claim against JAB Produce for a lump sum wage differential. Respondent introduced into evidence the Commission's mainframe database record showing that Petitioner settled the claim against JAB Produce for a lump sum of $125,000.00, representing a reduction of earning capacity. Petitioner admitted that approximately five months later, in June of 2009, he went to work for Respondent doing the same kind of work he had done for JAB Produce.

The medical records show that on December 11, 2009, Petitioner began treating with Dr. Steven Bardfield at Hinsdale Orthopaedics, complaining of low back and proximal flank pain, amongst other things. Dr. Bardfield noted: "He is working as a dock worker. He is actually working regular duty now. He notes that because he does repetitive lifting, his back is bothering him somewhat. He has chronic hamstring tightness and he feels that the hamstring is contributing to his symptoms proximally in the left leg." Dr. Bardfield recommended home exercises and prescribed Norco. Between February and March of 2010, Petitioner requested frequent refills of Norco, complaining of persistent low back pain and stating he needed to take four to five Norco tablets a day to be able to continue to work. This prompted Dr. Bardfield to refer Petitioner to Dr. Sapna Rathi for pain management.

On April 23, 2010, Petitioner began receiving pain management from Dr. Rathi. Petitioner complained of chronic low back pain with radiation down the legs, the left worse than the right. He also complained of worsening spasm and occasional stiffness. Dr. Rathi noted: "The patient states that he has been back to work since 2009, around May or June, and does do a great deal of heavy lifting at work. He states that increased lifting will flare-up his low back pain at times. He complains of occasional numbness, tingling, and burning in the low back with spasm and stiffness in the low back. He states that his average pain is about 5-6/10 intensity but well relieved with Norco. He is on Norco 10/325 mg five to six a day." Dr. Rathi performed bilateral sciatic nerve blocks, refilled Norco and recommended a TENS unit. Thereafter, Petitioner regularly followed up with Dr. Rathi, reporting no lasting improvement. Dr. Rathi performed sciatic nerve blocks and trigger point injections, and continued to prescribe Norco. Petitioner told Dr. Rathi the injections enabled him to continue to work. On September 8, 2010, Dr. Rathi noted: "He is doing about the same if not slightly worse due to increased activity. He has recently started another business and states that the increased work load is flaring up his low back pain and spasms." Petitioner was still under Dr. Rathi's care at the time of the work accident on November 15, 2010.

The medical records further show that on November 15, 2010, Petitioner saw Dr. Collins after the work accident. Dr. Collins noted: "He was on a standing forklift from what he is describing, and he was driving it when another driver hit him. *** [The patient] himself was not hit by the other machine, but [the patient] saw the other machine coming and was trying to get off and the machine hit him going about 20 miles an hour and [he] said he was thrown through the air landing awkwardly on his right knee and then falling to the ground." Petitioner

complained of pain in the knee; however, he stated the main problem was his back. X-rays of the right knee showed mild arthritic changes. Dr. Collins recommended seeing Dr. Lorenz as soon as possible. On November 16, 2010, Petitioner saw Dr. Rathi, complaining of low back pain radiating down the legs. Dr. Rathi refilled Norco and prescribed a Medrol Dosepak and Opana.

A lumbar MRI performed November 18, 2010, showed: postoperative changes from L3 through S1; degenerative disc disease at L2-L3 and L3-L4 with mild bulging and degenerative facet arthrosis; and "[a]t L2-L3, there is moderate canal stenosis which is partially developmental in nature with superimposed disk bulging and mild facet hypertrophy." An MRI of the right knee, also performed November 18, 2010, showed: "[P]artial meniscectomy change in the anterior horn and anterior body of the medial meniscus. Degenerative chondral erosive change in the medial tibiofemoral compartment primarily involving the medial femoral condyle. Chondromalacia patella." On November 24, 2010, Petitioner followed up with Dr. Rathi. Dr. Rathi performed another set of sciatic nerve blocks and trigger point injections. Thereafter, Petitioner continued to regularly follow up with Dr. Rathi through September 28, 2011, reporting gradually worsening symptoms. Dr. Rathi continued to perform injections and prescribe narcotic pain medications.

On December 2, 2010, Petitioner saw Dr. Lorenz, complaining his chronic low back pain was worse since the accident and radiated to the legs. Flexion/extension X-rays of the lumbar spine showed posterior spurring at L2-L3 and a 3 mm retrolisthesis of L2 on L3. Dr. Lorenz reviewed the MRI, noting: "He has spondylosis with a retrolisthesis of L2 on L3 giving rise to moderate central stenosis and bilateral foraminal stenosis at L2-3. He has a high intensity zone in the posterior annulus at L2-3 consistent with a small annular tear that is reflected in the report as well. He has acquired moderate stenosis secondary to diffuse disk bulge and a retrolisthesis and congenitally short pedicles." Dr. Lorenz recommended epidural steroid injections at L2-L3 and continued pain management. Regarding causal connection, Dr. Lorenz stated: "It is of medical and surgical certainty that the patient's objective and subjective findings are consistent with L2-3 annular tear, low back pain, and radiculopathy with an aggravation of spondylosis and spinal stenosis. This emanated out of an injury on November 15, 2010, where he was working for [Respondent] when he was struck by another pallet jack."

On January 7, 2011, Dr. Collins performed an arthroscopic chondroplasty of the right knee, noting previous operative changes and performing chondroplasty of the medial condyle and medial tibial plateau. No meniscal tears were noted. Dr. Collins stated: "There really were not any unstable flap tears or any further treatment needed to the patellofemoral joint." On January 20, 2011, Petitioner followed up with Dr. Collins, who stated: "I reviewed his arthroscopic findings with him. He does have some chondromalacia and this knee is never going to be perfect and he has to understand that. I think physical therapy will help him. I have encouraged weight reduction. I would like to see him do a lot of nonimpact loading type activities. I told him he can go back to light duty work but it would be mostly sedentary sitting at a desk but this does not really matter since he cannot go back to work anyway because of his

back." On January 26, 2011, Petitioner consulted Dr. Robert Daley for a second opinion regarding his right knee. Dr. Daley suggested Synvisc injections in the event physical therapy failed.

On January 20, 2011 and March 9, 2011, Petitioner followed up with Dr. Lorenz, complaining of significant/severe low back pain with radiation down the legs. Dr. Lorenz discussed surgery and continuing pain management.

On September 8, 2011, Dr. Avi Bernstein, a spine surgeon, examined Petitioner at Respondent's request. Petitioner complained of low back pain radiating to the buttocks and left leg. Dr. Bernstein reviewed the MRI from November 18, 2010, and opined: "This patient is suffering from recurrent low back pain as the result of transition syndrome at the L2-3 level. This is a pre-existing degenerative condition which probably led [to] a bulging and retrolisthesis. Based on the history provided by the patient, this was aggravated as a result of work related incidents. The patient appeared to have some increasing back pain following the initial right knee injury but more specifically suffered a significant trauma on November 15, 2010 that appears to have resulted in significant increase in his back symptoms." Dr. Bernstein recommended extending the fusion.

On October 6, 2011, Petitioner returned to Dr. Collins, complaining of some worsening in the right knee symptoms. X-rays showed some joint space narrowing in the medial compartment and patellofemoral joint. Dr. Collins diagnosed moderate arthritic changes, primarily in the medial compartment, and told Petitioner "he is headed towards a knee replacement." Dr. Collins performed a steroid injection into the knee.

On October 26, 2011, Dr. Bernstein performed fusion surgery at L2-L3. Postoperatively, Petitioner underwent pain management and physical therapy. The records from the Center for Pain Management show Petitioner was prescribed Opana, Oxycodone, Valium and Cymbalta. Petitioner also underwent multiple injections, reporting a 20 percent overall improvement. The pain management specialist, Dr. Firdaus Hashim, noted concerning behavior regarding Petitioner's use of narcotic pain medications. Dr. Hashim referred Petitioner for evaluation to Dr. Peter Brown, a pain psychologist, and then to Dr. Abhin Singla for inpatient detox.

On February 28, 2012, Petitioner returned to Dr. Collins, who noted: "[The patient] is continuing to have trouble with his right knee, now even his left knee is starting to act up on him." Dr. Collins performed a Synvisc injection into the right knee. On May 10, 2012, Petitioner saw Dr. Collins about his left knee. Dr. Collins noted: "There is no one specific major injury that occurred although he thinks he possibly may have hurt it at the time of his original accident." X-rays showed minimal degenerative changes. An MRI of the left knee performed June 7, 2012, showed chondral fissuring especially of the patellofemoral and medial compartments, and no meniscal tears.

On June 28, 2012, Dr. Bernstein noted that Petitioner had a stable fusion and wished to undergo a detox program to get off his pain medications. On July 12, 2012, Petitioner underwent a functional capacity evaluation at Dr. Bernstein's request, which placed him at the light physical demand level, with occasional lifting up to 28 pounds. On August 16, 2012, Dr. Bernstein imposed permanent restriction per the functional capacity evaluation. In September through November of 2012, Petitioner saw Dr. Singla as an outpatient. Dr. Singla prescribed Suboxone, but was unable to wean Petitioner off his pain medications.

On July 18, 2012, Dr. Collins went over the MRI findings with Petitioner and explained that "he does have some arthritis in his left knee though it is not as bad as his right." Regarding the etiology of the symptoms in the left knee, Dr. Collins stated: "I have told him that although I do think that he is somewhat prone to arthritis and he very well may have gotten arthritis in his knee even if he had not had this injury. I do not think there is any doubt that the injury combined with the problem with his right knee and his back all together added to the stress on his left knee and have at the very least aggravated this underlying condition." Dr. Collins performed a steroid injection into the left knee. On September 11, 2012, Petitioner underwent injections into both knees. On October 23, 2012, Petitioner complained to Dr. Collins of significant, persistent problems with the right knee and inquired about a knee replacement. Dr. Collins did not think a knee replacement was appropriate "in someone with an x-ray like this." Dr. Collins ordered an MRI to rule out internal derangement. The MRI, performed October 29, 2012, showed chondral fissuring especially in the lateral and patellofemoral compartments, postoperative changes, and a probable perimeniscal or ganglion cyst lateral to the distal semimembranosus tendon.

On January 7, 2013, Petitioner was examined by Dr. Bernard Bach, an orthopedic surgeon, at Respondent's request with respect to the knee conditions. Petitioner reported significant symptoms in the knees and asked about a knee replacement. X-rays showed minimal to mild joint space narrowing in the medial compartment of the right knee. With respect to the right knee, Dr. Bach opined Petitioner's clinical symptoms are consistent with early medial compartment degenerative joint disease and patellofemoral syndrome, and recommended an unloader brace. With respect to the left knee, Dr. Bach opined the symptoms came from the medial plica syndrome. Dr. Bach did not think surgery on either knee would be appropriate. Regarding causal connection of the right knee condition, Dr. Bach stated: "I did not believe that either injury [on April 7 or November 15, 2010] actually caused any arthritis, may have temporarily aggravated. I suspect he had previous history of chondromalacia in both the medial compartment and the patellofemoral compartment at the time of the April 7 injury." With regard to the left knee, Dr. Bach opined the condition was not causally connected to either accident.

On March 7, 2013, Petitioner saw Dr. Bernstein's partner, Dr. David Spencer, who noted: "[The patient] seemed to be in relatively stable condition until just a couple days ago when he was getting off of the toilet, he suffered severe back pain at the upper end of his previous surgery." X-rays showed some junctional degeneration at L1-L2. Dr. Spencer prescribed Prednisone and rest. On March 28, 2013, Petitioner followed up with Dr. Bernstein, reporting no real improvement in his pain. Dr. Bernstein stated: "This appears to be transitional syndrome

related to his prior surgery with this new incident superimposed on it." An MRI showed a left-sided disc protrusion at L1-L2 immediately adjacent to the fusion. Dr. Bernstein did not think the disc protrusion was severe enough to warrant surgery. On June 6, 2013, Petitioner followed up with Dr. Bernstein, who noted the symptoms seemed to be under adequate control. Petitioner also showed Dr. Bernstein a video of the accident on November 15, 2010. Dr. Bernstein stated: "Evaluating the videotape today certainly demonstrates a significant injury that is likely responsible for the back injury for which I operated him." Dr. Bernstein instructed Petitioner to follow up as needed.

On August 2, 2013, Petitioner consulted Dr. Ronald Silver, an orthopedic surgeon, regarding both knees.[1] Dr. Silver recommended arthroscopic surgery, first on the right knee, then on the left. On October 8, 2013, Dr. Silver performed a right knee arthroscopic tricompartmental synovectomy, debridement and removal of loose bodies. Postoperatively, Petitioner made slow progress in physical therapy. Dr. Silver kept Petitioner off work. On January 24, 2014, Dr. Silver noted improvement in the right knee. However, he noted "significant cartilage loss" and cautioned that Petitioner is likely to require further arthroscopic debridement in the next several years and eventually a right knee replacement. Dr. Silver continued to recommend arthroscopic surgery on the left knee once the right knee recovered. On January 29, 2014, Dr. Silver wrote to Petitioner's attorney, stating: "The need for this arthroscopic surgery [of October 8, 2013] is a continuation of [the patient's] work injury as noted above as his knee problems never resolved with persistent symptoms in spite of the two arthroscopic surgeries performed elsewhere ***. He has improved significantly after the arthroscopic surgery performed; however, he will have permanent problems with regard to squatting, kneeling, crawling and climbing due to the cartilage loss he sustained from the work injuries above."

Dr. Bernstein testified via evidence deposition on July 3, 2013. Dr. Bernstein testified consistently with his medical records and report that the work accident aggravated Petitioner's low back condition. Dr. Bernstein noted the functional capacity evaluation found Petitioner "to be functioning at the light physical demand level; about a 25 pound lift approximately." Regarding Petitioner's subsequent problems with the L1-L2 level, Dr. Bernstein testified Petitioner was at a greater risk of that segment's problems because of the fusion at L2-L3, in addition to the fusion from L3 through S1. Dr. Bernstein further stated: "[H]e has problems at L1-2. It's a symptomatic level. I believe that it's a reasonable source of pain and that it probably does limit his ability to function at work." Dr. Bernstein opined: "He can't work as a manual laborer. That's certain. Nor will he ever be able to. ¶ He has the entire lumbar spine fused almost and he's looking at future injury if he does any type of physical work activity. * * * I would say that with respect to the spine alone it would be a sedentary to light position max and that would be for the remainder of his life." Dr. Bernstein further testified that Petitioner needed to find a job that allowed him to change positions frequently. Petitioner could squat occasionally, but not

[1] Petitioner testified that Dr. Collins referred him to Dr. Silver because of his insurance situation. The record contains a "to whom it may concern" letter from Dr. Collins stating that Petitioner's medical insurance was now through Public Aid, which his practice did not accept. Petitioner was therefore instructed to seek care elsewhere.

bend at the waist. Any increased physical activity or stress to the low back could cause more problems and possibly lead to further surgery. Dr. Bernstein hoped Petitioner would only need symptomatic care in the future. However, Petitioner might need another add-on fusion. Further, Dr. Bernstein thought Petitioner's knee condition could exacerbate the back condition. "In other words, if he walks with a limp and he doesn't have good gait mechanics, that could result in increased stress to his spine." In sum, Dr. Bernstein thought Petitioner's prognosis was guarded, and his restrictions should be sedentary to light duty. Dr. Bernstein limited Petitioner to working no more than eight hours a day.

Petitioner testified that he looked for work on his own for a period of time. However, he faced significant obstacles because of his symptoms and because he was a convicted felon, having served almost three years in prison. Petitioner introduced into evidence his job search logs spanning the time period from January 7 through February 15, 2013. Petitioner further testified that on April 1, 2013, he underwent a vocational evaluation at Vocamotive at the request of his attorney. The vocational rehabilitation counselor opined that he was unemployable. Petitioner then applied for Social Security disability benefits. Petitioner described his current condition as follows: "I can't sit for long periods of time. I can't walk for long periods of time. I can't lift. I can't lift anything. I'm a big guy. *** I pick up something, all my bones will fall apart." Petitioner stated that he is in constant pain and continues to receive pain management. He is on Suboxone, Cymbalta and Valium.

The vocational assessment report from Vocamotive states that Petitioner, who was 44 years old at the time, reported significant pain and disability. Petitioner further reported a difficult upbringing, poor formal education, and receiving a GED in 2002 while he was in a federal prison. Petitioner also reported "he had been arrested 40 to 45 times related to violence." Petitioner knew how to use a computer, but had no other transferrable skills. Petitioner's work experience was mainly in loading, unloading and delivering produce. Petitioner reported looking for work since December of 2012 by asking in person at ocal gas stations and McDonald's restaurants. The vocational rehabilitation counselor, Kari Stafseth, opined that Petitioner "has lost access to his usual and customary job and line of occupation," and he was "facing several barriers that will preclude him from obtaining gainful employment." Aptitude tests showed Petitioner would have difficulty obtaining employment in a clerical setting. Petitioner's criminal background precluded working in the areas of security or cashiering. Ms. Stafseth concluded: "Given the situational factors at play including [the client's] lack of transferrable skills, limited work history, criminal record, physical restrictions including the need for part time employment and difficult economy, it is the opinion of this consultant that [the client] does not have access to a stable, meaningful labor market. Thus, it is the opinion of this consultant that [the client] has disability which is total."

The Arbitrator found: "[T]he incident of November 15, 2010 resulted in an aggravation of the pre existing condition at L2-3, necessitating the care of Drs. Lorenz and Bernstein for the low back through August 16, 2012 only. The Arbitrator also finds the incident of November 15, 2010 resulted in a temporary aggravation of Petitioner's pre existing right knee condition,

necessitating Dr. Collins' third chondroplasty to the right knee January 17, 2011 and from which Petitioner was back to base line as of October 16, 2011." Correspondingly, the Arbitrator awarded: medical expenses for treatment of the low back condition through August 16, 2012, and the right knee condition through October 16, 2011; and temporary total disability benefits from November 16, 2010, through October 28, 2012 (the period to which Respondent stipulated). Regarding permanent disability, the Arbitrator found: "Petitioner, as a result of the accident of November 15, 2010, is unable to return to his previous line of employment. The Arbitrator further finds that Petitioner has failed to meet his burden of proof in proving an 'odd lot' permanent total disability. Therefore, the Arbitrator finds that a finding of 'loss of trade' is appropriate in this matter." The Arbitrator awarded benefits representing permanent disability to the extent of 50 percent of the person as a whole.

The Commission modifies the Arbitrator's award with respect to medical benefits and permanent disability. The Commission finds that the Arbitrator erred in denying medical benefits for the low back injury after August 16, 2012. The Commission finds the medical care for the low back condition and the pain management continued to be causally connected to the accident on November 15, 2010. The Commission relies on the testimony of Dr. Bernstein that due to Petitioner's lumbar fusion and adjacent segment problems at L1-L2, he would likely need ongoing care.

Turning to permanent disability, the Commission agrees with the Arbitrator that Petitioner failed to prove an 'odd lot' permanent total disability. The record shows symptom magnification for secondary gain, drug seeking behavior, and poor motivation to return to the workforce. Further, the Commission finds the loss of trade award is inappropriate. Petitioner has already been compensated for loss of trade in the case against JAB Produce. Approximately five months after settling his claim against JAB Produce, Petitioner went to work for Respondent doing the same kind of work he had done for JAB Produce. The accident on November 15, 2010, necessitated extending the fusion to the L2-L3 level and resulted in some additional restrictions. Furthermore, the L1-L2 level is now symptomatic. The Commission finds the accident on November 15, 2010, caused an additional 30 percent disability to the person as a whole.

Lastly, the Commission makes two factual corrections to the Arbitrator's decision. The Commission strikes the Arbitrator's finding that "Petitioner has made no attempt to look for work since his release by Dr. Bernstein August 16, 2012." The record shows Petitioner looked for work for approximately five weeks in January and February of 2013. The Commission also corrects the Arbitrator's finding that Dr. Bernstein did not connect the pathology at the L1-L2 level to the accident on November 15, 2010. As noted, Dr. Bernstein testified that Petitioner was at a greater risk of problems at L1-L2 because of the fusion at L2-L3, in addition to the fusion from L3 through S1.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 9, 2014, is hereby corrected and modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $605.68 per week for a period of 101 6/7 weeks, from November 16, 2010, through October 28, 2012, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills in evidence related to treatment of the low back condition and pain management. Further, Respondent shall pay the medical bills in evidence related to treatment of the right knee condition through October 16, 2011. All bills shall be paid as provided in §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $545.11 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 percent disability to the person as a whole.

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 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.

JUN 16 2016

DATED:
o-05/19/2016
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EMERY, EDWARD
Employee/Petitioner

Case# **10WC045050**
10WC045051

MICHAEL J NAVILIO & SON
Employer/Respondent

16IWCC0405

On 9/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
DEREK SLAX
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

0210 GANAN & SHAPIRO PC
ELAINE T NEWQUIST
210 W ILLINOIS ST
CHICAGO, IL 60654

16IWCC0405

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

Edward Emery
Employee/Petitioner

v.

Michael J. Navilio & Son
Employer/Respondent

Case # **10 WC 45050**

Consolidated cases: **10 WC 45051**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **July 24 and August 25, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11/15/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$47,243.04**; the average weekly wage was **$908.52**.

On the date of accident, Petitioner was **42** years of age, married with **5** 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 **$61,692.83** for TTD, **$0** for TPD, **$3,028.40** for maintenance, and **$0** for other benefits, for a total credit of **$64,721.23**.

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

ORDER

The Arbitrator finds causal connection between the work incident of November 15, 2010 and the Petitioner's condition relative to the low back only through August 16, 2012 and to the right knee only through October 16, 2011.

Respondent is liable for the fee schedule amounts due on medical bills incurred with Drs. Lorenz and Bernstein, operative and ancillary charges attendant thereto, and for treatment with the Centers for Pain Management on referral from Dr. Bernstein, through August 16, 2012. Respondent is also liable for the fee schedule amounts due Dr. Collins, including operative charges and ancillary care attendant thereto, through October 16, 2011. Charges to any other provider and/or beyond those dates are denied.

Petitioner is entitled to the sum of $605.68 for a period of 1016/7 weeks for the period of November 16, 2010 through October 28, 2012; claim for further compensation is denied.

Petitioner is entitled to the sum of $545.11 per week for a period of 250 weeks, as the incident of November 15, 2010 resulted in permanent partial disability to the extent of 50% of a person.

Claim for penalties and attorneys' fees 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.

David A. Kane
Signature of Arbitrator

September 9, 2014
Date

SEP 9 - 2014

Edward Emery v. Michael J. Navilio and Son
10 WC 45050

Statement of Facts: Petitioner's past claims history is significant for multiple prior work related injuries involving his left leg, left arm, right foot and right knee, the last the subject of companion case 10 WC 45051. On February 6, 2004 Petitioner was employed with JAB Products as a produce loader when he sustained accidental injuries to his low back resulting in a three level fusion from L3 through S1. Hardware was removed in response to report of persistent low back and left leg pain. Petitioner was ultimately released per a FCE on October 6, 2006 to "light to medium" duty, with no lifting over 35 lbs on an occasional basis only, no work over an 8 hour day, and to alternate sitting and standing. He was cleared to return to work on this basis by Dr. Lorenz on October 10, 2006, and was told these restrictions were permanent. He could not return back to his former employment.

As part of that pending workers' compensation case Petitioner was examined by Dr. Andersson on March 15, 2007. Petitioner reported continued low back pain. He was told he would need permanent work restrictions. He returned to Dr. Lorenz June 5, 2007, reporting continued low back and left leg pain. Dr. Lorenz again recommended permanent light duty and vocational rehabilitation. Petitioner settled the 2004 low back case for $125,000.00, the discounted present value of a wage differential. Settlement contracts were approved January 13, 2009. Petitioner then returned to work full duty as a

produce loader, now working for Respondent, on June 19, 2009. At trial, Petitioner testified his duties for Respondent were the same as those he had performed for JAB Products before his low back injury with them.

Petitioner sought further care for continued low back as well as bilateral knee pain with Dr. Bardfield December 11, 2009. He was directed to undergo a MRI and was given a prescription for Norco. He reported no improvement in low back and left leg pain in February, 2010, and by March 19, 2010 reported to Dr. Bardfield he was taking 4 -5 Norco per day. He called Dr. Bardfield for another Norco refill April 9, 2010, at which time he was referred to Dr. Rathi for pain management. Petitioner first saw Dr. Rathi April 23, 2010, reporting chronic low back pain and left leg pain with failed back syndrome, with some newer right leg pain. He was given a TNS unit and a back brace. He reported no improvement June 10, 2010, and was given bilateral sciatic nerve blocks and lumbosacral trigger point injections along with prescriptions for Norco and Opana.

Petitioner reported to Dr. Rathi he was worse and received further lumbar injections July 8, August 11, September 8, October 6 and October 27, 2010. Petitioner also told Dr. Rathi of a new business he had started, with the increased work load flaring up his low back pain. At trial Petitioner testified his wife had started a produce company and he was helping her run it. He also admitted that as of November 15, 2010, he was still under Dr. Rathi's care for ongoing low back and bilateral leg pain.

On November 15, 2010 Petitioner was on a stand up forklift when he was struck by another stand up forklift. He sought "emergency" care with Dr. Collins that day, reporting some right knee pain but that his knee was "still not perfect" from the prior procedure just months before. His primary complaint was low back pain, and Dr. Collins referred him to his associate Dr. Lorenz.

Petitioner was seen for a preset appointment with Dr. Rathi November 16, 2010 and reported continued low back pain with radiation down both legs, as he had in the past. Dr. Rathi refilled his prescriptions. Petitioner returned to Dr. Rathi with the same complaints November 24, 2010, at which time the doctor recommended some facet injections. Petitioner had one under Dr. Mehta's care January 4, 2011 but reported no improvement when seen by this doctor again January 19, 2011.

Petitioner did undergo a MRI of the right knee under Dr. Collins' care November 18, 2010. He had an injection to the right knee December 8, 2010, and report the right knee was better. He sought another opinion for the right knee January 26, 2011 with Dr. Daley, reporting right knee pain "off and on in the past."

Petitioner continued under Dr. Rathi's care, receiving lumbar injections and prescriptions.

Petitioner had undergone a lumbar MRI on November 18, 2010, which showed extensive post surgical changes from L3 through S1 with moderate canal stenosis, partially developmental in nature, with superimposed disc bulging and mild facet hypertrophy at L2-3. Dr. Lorenz saw Petitioner December 2, 2010, and diagnosed an annular tear at the L2-3 level with aggravation of spondylosis and stenosis at that level from the November 15, 2010 work injury. He recommended a laminectomy and fusion at that level. Petitioner was examined by Dr. Bernstein at the request of Respondent on September 8, 2011. He diagnosed a transitional syndrome at L2-3, a pre existing condition aggravated by the work injury of November 15, 2010. He recommended an add on decompression and fusion at that level. Petitioner underwent that procedure under Dr. Bernstein's car on November 15, 2011.

Post operatively Petitioner reported to Dr. Bernstein he was "doing well." He was placed in therapy. He was referred to the Centers for Pain Management to wean off narcotic medication in March, 2012. Petitioner told Dr. Hashim at that facility he did not wish to be weaned off narcotics March 12, 2012, and a rapid detox program was recommended. Petitioner instead chose to treat with Dr. Brown and received counseling for multiple issues include pain management and anger management.

Dr. Bernstein prescribed a FCE to assess work capabilities on April 30, 2012 and again on June 28, 2012. Petitioner underwent a FCE at ATI on July 12, 2012 which cleared him to lifting up to 28 lbs. Dr.

Bernstein cleared him to return to work at that level August 16, 2012 and discharged him from care at that time. Dr. Bernstein testified Petitioner's work level and capabilities were at the same level as when Petitioner had been cleared to return to work "light to medium" duty back in 2006.

Meanwhile, Petitioner returned back to Dr. Collins May 10, 2012, reporting continuing pain in the right knee "for years," along with pain in the left knee. He was sent for a left knee MRI. He returned to Dr. Collins July 18, 2012, reporting bilateral knee pain and seeking an opinion as to whether the left knee was related to the right knee. Dr. Collins advised Petitioner he would have developed the arthritis found in the left knee with or without the prior right knee injury.

Petitioner sought another opinion on his knees from Dr. Collins' associate Dr. Gilligan September 11, 2012, and was told he had arthritis in both knees. He offered Petitioner injections. Petitioner underwent a MRI of the right knee October 29, 2012. This showed chondral fissuring, effusion and a ganglion cyst but no meniscal tearing. Dr. Collins prescribed an arthroscopic evaluation of the right knee November 1, 2012.

Petitioner was examined by Dr. Bach at the request of Respondent on January 7, 2013. He diagnosed patellofemoral syndrome in both knees with medial compartment arthritis, chondromalacia, and degenerative joint disease in the right knee. He saw no evidence of any surgical lesion in the right knee or any basis for surgery. He

found the condition of the right knee after the November 15, 2010 incident was pre existing without any evidence of change or aggravation.

Petitioner was seen by Dr. Bernstein's associate Dr. Spencer in March, 2013 after he developed low back pain getting off the toilet. A new MRI showed a left sided disc protrusion at L1-2.

Dr. Bernstein testified on July 3, 2013 that while he did believe the surgery he performed at L2-3 was brought on by the work incident of November 15, 2010, the prior fused levels from L3 through S1 did put Petitioner at greater risk for injury or pathology at the L2-3 level, and that Petitioner could have developed that pathology without any aggravating factor at all. He noted Petitioner did already have some retrolisthesis at the L2-3 level even before the November 15, 2010 incident. He did not relate the newer pathology at L1-2 to the work injury, rather, to the incident getting off the toilet, but did not feel the condition at this level imposed any limitations on Petitioner or his work capabilities.

He testified the permanent restrictions he had imposed in 2012 were the same as Dr. Lorenz had imposed back in 2006, and that if Petitioner had chosen to do more he would have been "at risk for accelerating an adjacent segment process or causing a new injury." He noted that from a medical standpoint Petitioner had been experiencing continuing low back problems even before November

15, 2010, typical for a three level fusion and with the "extent of damage already present at L2-3."

Petitioner sought care for his right knee with Dr. Silver, who would accept public aid patients. He performed a right knee arthroscopic surgery October 8, 2013 for articular cartilage fracture of the patella and trochlea, cartilage fragmentation of the medial compartment, loose bodies and tri compartmental synovitis. Left knee surgery was also being discussed.

Petitioner returned to Dr. Bernstein April 7, 2014, reporting continued low back pain as well as bilateral knee pain. X-rays showed a healed fusion with some degenerative changes. No specific care was recommended.

Petitioner has made no attempt to look for work since his release by Dr. Bernstein August 16, 2012. He has applied for Social Security disability. He admitted at trial to a felony conviction and multiple arrests, which impact his ability to become employed.

Conclusions of Law

Regarding F) is Petitioner's current condition of ill being causally related to the injury, the Arbitrator finds the following:

Petitioner had a long standing low back problem with ongoing pain in the low back and down both legs. He had undergone a three level fusion from L3 through S1 back in 2005, with hardware removal in

response to persistent pain in 2006, and per Dr. Bernstein would have had both ongoing pain and the potential for developing pathology at the L2-3 level without an aggravation. He had been cleared to "light to medium" duty for that condition, and was under active medical care with use of lumbar injections and medications at the time of the November 15, 2010 incident. Following that November 15, 2010 incident, he continued receiving the same care from Dr. Rathi and injections from Dr. Mehta.

Dr. Lorenz did diagnose disc pathology requiring surgery at the L2-3 level. Dr. Bernstein agreed, recommending a decompression and extension of the fusion to that level, and Petitioner agreed to undergo that procedure under Dr. Bernstein's care. Dr. Bernstein testified the work incident of November 15, 2010 was sufficient aggravation to necessitate the procedure he performed at the L2-3 level. He declared Petitioner at maximum medical improvement as of August 16, 2012, cleared him back to the same work level Petitioner had been released to by Dr. Lorenz back in 2006, and testified later pathology at the L1-2 level was not related to the work incident of November 15, 2010.

Petitioner also had a longstanding right knee problem, with a history of bilateral knee pain and care since 2005. He would tell Dr. Rathi in June, 2010 that Dr. Lorenz had already told him to anticipate a right total knee replacement. Following the November 15, 2010 incident he returned to Dr. Collins for care, underwent a third chondroplasty of the right knee for ongoing chondromalcia January 17, 2011, and was

found to have ongoing arthritis in both knees by Dr. Collins, his associate Dr. Gilligan and by Dr. Bach. Dr. Bach opined any ongoing problems in the right knee were not related to the work incident of November 15, 2010, as of January 7, 2013.

The Arbitrator therefore finds that the incident of November 15, 2010 resulted in an aggravation of the pre existing condition at L2-3, necessitating the care of Drs. Lorenz and Bernstein for the low back through August 16, 2012 only. The Arbitrator also finds the incident of November 15, 2010 resulted in a temporary aggravation of Petitioner's pre existing right knee condition, necessitating Dr. Collins' third chondroplasty to the right knee January 17, 2011 and from which Petitioner was back to base line as of October 16, 2011, when Dr. Collins began offering treatment for arthritis in the right and later to the left knee.

Regarding J) what medical bills are due, the Arbitrator finds the following:

Respondent is liable for the reasonable, customary and fee scheduled charges due Drs. Lorenz and Bernstein for low back care through August 16, 2012, for operative charges and ancillary care including therapy and pain management with Centers for Pain Management, on referral from Dr. Bernstein, all for the low back through August 16, 2012 only. No services for the low back after that date are awarded. The Arbitrator also finds Respondent liable for Dr. Collins' care including operative charges and ancillary care including therapy for the right knee through October 16, 2011. Ongoing care

with Dr. Rathi, Dr. Mehta, Dr. Patel, Dr. Hawkins, Dr. Daley, and later care with Dr. Silver, are expressly denied.

Regarding K) temporary total disability, the Arbitrator finds the following:

Petitioner is entitled to the sum of $605.68 per week for a period of 101 6/7 weeks, between November 16, 2010 and October 28, 2012. Petitioner was released to return to work by Dr. Bernstein with permanent restrictions on August 16, 2012. Respondent volitionally paid temporary total disability through October 28, 2012. Claim for further temporary total disability after that date is denied.

Regarding L) what is the nature and extent of the injury, the Arbitrator finds the following:

The Arbitrator, based on the above and after consideringt the entire record, finds that Petitioner , as a result of the accident of November 15, 2010, is unable to return to his previous line of employment. The Arbitrator further finds that Petitioner has failed to meet his burden of proof in proving an "odd lot" permanent total disability. Therefore, the Arbitrator finds that a finding of "loss of trade" is appropriate in this mater.

Accordingly, the Arbitrator finds that Petitioner is permanently disabled to the extent of 50% under section 8(d)2 of the Act.

Regarding penalties and attorneys' fees claimed, the Arbitrator finds the following:

There is no showing of unreasonable or vexatious conduct on the part of Respondent, which paid temporary total disability even after Petitioner was released to return to work at his prior restricted work level, and despite little to no evidence of any meaningful job search. Further, Respondent had medical basis to deny liability for any right knee care sought after Dr Bach's exam of January 7, 2013. Claim for penalties and attorneys' fees is therefore denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edward T. Emery,

Petitioner,

vs.

No. 10 WC 45051

Michael J. Navilio & Son, Inc.,

16IWCC0406

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 9, 2014, is hereby affirmed and adopted.

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

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

16IWCC0406

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: JUN 16 2016
o-05/19/2016
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EMERY, EDWARD
Employee/Petitioner

Case# **10WC045051**
10WC045050

MICHAEL J NAVILIO & SON
Employer/Respondent

16IWCC0406

On 9/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
DEREK S LAX
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

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STATE OF ILLINOIS)
)SS.
COUNTY OF)

16IWCC0406

☐ 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

Edward Emery
Employee/Petitioner

v.

Michael J. Navilio & Son
Employer/Respondent

Case # **10 WC 45051**

Consolidated cases: **10 WC 45050**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane** , Arbitrator of the Commission, in the city of **Chicago**, on **July 24 and August 25, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/7/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's condition of ill-being through May 24, 2010 ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**47,253.04**; the average weekly wage was $**908.52**.

On the date of accident, Petitioner was **42** years of age, married with **5** 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 $**6,143.32** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**6,143.32**.

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

ORDER

The Arbitrator finds causal connection between the work incident of April 7, 2010 and the condition of ill being as alleged relative to the right knee through maximum medical improvement and discharge to full duty May 24, 2010.

The Petitioner is entitled to the sum of $545.11 per week for a period of 43 weeks, as the injury of April 7, 2010 resulted in permanent partial disability to the extent of 20% loss of use of the right leg.

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

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

David A. Kane
Signature of Arbitrator

September 9, 2014
Date

SEP 9 – 2014

Edward Emery v. Michael J. Navilio and Son
10 WC 45051

Statement of Facts: Petitioner's prior claims history is significant for multiple prior workers' compensation injuries to his left leg October 4, 1994, his left arm October 13, 1997, and to his right foot May 1, 1998 and June 1, 1999. On February 6, 2004 he sustained an injury to his low back while working as a produce loader for JAB Products. He ultimately underwent a three level fusion from L3 through S1. Hardware was removed due to persistent low back and leg pain. He was ultimately released with permanent restrictions and could not return back to work as a produce loader. He settled the case for $125,000.00, as a discounted present value of a wage differential. Settlement contracts were approved January 13, 2009. Petitioner returned to work as a produce loader, now working for Respondent, on June 19, 2009.

Petitioner's prior medical history is significant for treatment of both knees. He reported to Dr. Zindrick he felt like both knees "are going to explode" in July, 2005, with the right knee worse than the left, difficulty climbing stairs or doing squats. He was sent for pain management with Dr. Lipov. A MRI of the right knee done September 9, 2005 was reviewed by Dr. Collins as showing arthritis, and he order therapy. When that failed, Petitioner underwent an arthroscopic chondroplasty of the medial condyle and patella for Grade III chondromalacia without meniscal tearing. Petitioner was again placed in therapy and saw Dr. Lipov for pain management for bilateral knee as well as low back pain.

Petitioner sought further pain management for continued low back and bilateral knee pain from Dr. Bardfield December 11, 2009. He was placed on Norco and referred to Dr. Rathi for pain management April 9, 2010. Petitioner told Dr. Rathi he had been told he would eventually need a right total knee replacement by Dr. Lorenz, who at that point Petitioner had not seen since 2005.

While working on April 7, 2010 Petitioner sustained a new injury to his right knee when a pallet he was standing on broke, causing him to twist the knee. He returned to Dr. Collins who ordered a MRI which showed a possible tear of the lateral meniscus, tri compartmental degenerative changes and mild chondromalacia deemed "similar to previous exam." Petitioner's last known right knee MRI had been in September, 2005. Dr. Collins performed a right knee surgery April 30, 2010, a chondroplasty of the medial condyle and patella. Grade III chondromalacia was again noted but no meniscal tearing. The Arbitrator notes this was the same procedure, with the same findings, as during the prior right knee surgery January 13, 2006.

Petitioner testified after the surgery his right knee was better. Dr. Collins recorded that Petitioner was "almost 100%." He was cleared and returned back to full duty May 24, 2010, per the doctor's records, although testified at trial he did not return back to full duty until June 8, 2010. He testified to some ongoing complaints with the right knee but continued working full duty and did not return for medical care

until after a new injury November 15, 2010, the subject of companion case 10 WC 45050.

Conclusions of Law

Regarding F) is Petitioner's present condition of ill being causally related to the injury, the Arbitrator finds the following:

Petitioner sustained a new injury when he twisted his right knee while working for Respondent on April 7, 2010. He was ultimately diagnosed with Grade III chondromalacia for which a chondroplasty was performed. The Arbitrator notes this was the same diagnosis and the same procedure Petitioner had undergone, without any known injury, back in January, 2006. Petitioner fully recovered, reported to Dr. Collins he was "almost 100%" and required no further medical care for the right knee after a full duty release and discharge from medical care May 24, 2010. Causal connection has therefore ended as of that date.

Regarding L) what is the nature and extent of the injury, the Arbitrator finds the following:

Petitioner sustained an aggravation of pre existing chondromalacia following the incident of April 7, 2010, for which a chondroplasty was required.

The Arbitrator, after considering the entire record, finds that as a result of the April 7, 201accident, Petitioner permanently lost 20% of the use of his right leg under section 8(d) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AMY RENEA BEARD,

Petitioner,

16IWCC0407

vs.

NO: 14 WC 11749

STATE OF ILLINOIS MURRAY DEVELOPMENT CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, permanent partial disability, medical expenses both current and prospective, and the Arbitrator's denial of Respondent's Motion to Reopen Proofs and the limitation of its presentation of an offer of proof, and being advised of the facts and law, vacates the Decision of the Arbitrator and further remands this case to the Arbitrator for further proceedings not inconsistent with this Decision and Opinion on Review. Because the Commission bases our vacation of the award on an evidentiary ruling, we will not discuss the medical records submitted into evidence which are not relevant to our instant decision.

Findings of fact and Conclusions of Law

1. Tricia Shipley, Respondent's workers' compensation coordinator, was called by Petitioner. She testified she filled out the report of injury Illinois Form 45 in the instant claim. Petitioner "slipped on ice when she went to sign in." There are several entrances, but the one Petitioner used to sign in was the main entrance where members of the public sign in as well. There was an entrance in the back which is always open. However, Petitioner worked in the storeroom and using the back entrance would be out of her way. She had no reason to dispute Petitioner's account of the accident.

2. Petitioner testified she worked for Respondent since November 3, 2003. The night before February 18, 2014, she removed snow on Respondent's premises with two co-workers. She was engaged in that activity from 4 pm, when she finished her normal shift, to about midnight. She worked in that activity for about eight hours, for which she was paid. She had no difficulty performing the snow removal.

3. Petitioner returned to the office at 5:02 am because she had to catch up on paperwork. Respondent went from six people to two people in her job and the remaining employees had to work overtime to keep up with all the paperwork. When she arrived it was still dark, and she parked right next to the administration building, as close to the doors as possible. The door at the very back of the building would be open at 5 am, but she would not use that entrance because she would have to come back all the way though the building to the front.

4. Petitioner got out of her truck and her foot slipped out from underneath her. She never fell completely; she put her right hand down and caught herself. Immediately, she felt pain in her back. She had never had pain in, or treatment of, her back previously. She sought medical attention immediately. Petitioner testified she did have previous workers' compensation claims for an injury which resulted in the replacement of two cervical discs and another when she broke a finger.

5. Petitioner testified that currently she has pain in her lower back that goes to her right buttock and down her right leg. She has also started to have problems with her left side, but not as bad as the right. The pain is stabbing, burning. Sometimes it is so bad that she falls. Dr. Raskas has recommended surgery which Petitioner wants. Petitioner would not have another appointment with Dr. Raskas until surgery.

6. After direct was completed, the Arbitrator noted that Petitioner was standing up. She had observed Petitioner sitting by her lawyer leaning toward the left side "as though she didn't want to sit on her right buttock." The Arbitrator also noted that "when she got up to testify, she was sitting more straightly in the chair, however, it was very erect, and now she's standing up."

7. On cross examination, Petitioner testified she had no dispute with Ms. Shipley's testimony that the public also signs in where she signs in. She agreed that she received non-occupational disability benefits while she has been off work. She has not seen Dr. Raskas since her symptoms got so bad that she sometimes falls. She has not followed up with her general practitioner or at an emergency room for these symptoms. She currently takes Percocet and Flexeril.

8. Another hearing was held on October 28, 2015 in which Respondent presented its Motion to Reopen Proofs. Respondent wanted to present an offer of proof in support of her motion.

9. Petitioner objected, noting that there was no affidavit supporting the motion, and that going into the substance of the evidence Respondent wanted to submit would "taint" the case. The Arbitrator indicated she did not want to hear the substance of the evidence and Respondent's lawyer indicated she would do her "best to redact."

10. Respondent's lawyer then asserted that while she was aware that Petitioner would testify she was not aware she would testify about events occurring prior to the accident. She had no way of verifying her testimony of prior events during the hearing. "It was only after and through a couple of days of document review and pulling documents at the facility that [she] was able to verify, and as Respondent alleges, that she testified under oath untruthfully with regard to events that occurred prior to her accident."

11. Furthermore, Respondent's lawyer stated that she had three witnesses present to testify and she wanted "to make an offer of proof" as to the testimony. Later, Respondent's lawyer suggested that the testimony would go to credibility and causation because Petitioner alleged she "was so healthy in fact that up until her date of accident she was able to do X."

12. The Arbitrator denied Respondent's motion. She also agreed with Petitioner that the issues of accident and causation were disputed throughout and Respondent could have found and presented this evidence at arbitration if it showed due diligence.

13. In her subsequent decision, the Arbitrator found Petitioner proved a compensable accident on February 18, 2014. She specifically noted Petitioner's condition prior to the date of accident and her ability to shovel snow extensively the previous night. She awarded Petitioner 27&1/7 weeks of temporary total disability benefits, $37,117.14 in current medical expenses, and ordered Respondent to authorize and pay for prospective surgery recommended by Dr. Raskas.

Respondent argues that the Arbitrator erred in at least not allowing an adequate offer of proof. It stresses that the Commission is bound by the Illinois Rules of Evidence, unless they conflict with the Act or Commission rules. It points out that Rule of Evidence 103(b) provides that an offer of proof must be made to preserve a claim of error for appeal.

Respondent cites cases which hold that refusal to allow an offer of proof is generally considered error. *See, People v. Thomkins*, 181 Ill. 2d 1 (1989); *In Re Estate of Undziakiewcz,* 54 Ill App. 2d 382 (1st Dist. 1964). Respondent then cites the language of the Arbitrator in her decision in which she quotes her specific finding that Petitioner performed the eight hours of snow shoveling prior to the accident. Petitioner argues the Arbitrator was correct in denying Respondent's Motion to Reopen Proofs. She stresses that the reopening of proofs is discretionary with the Arbitrator. In addition, she argues that "allowing" an offer of proof is different than "accepting" an offer of proof.

Petitioner argues that the purpose of an offer of proof is to "disclose to the trial judge and opposing counsel the *nature* of the offered evidence to enable a reviewing court to determine whether the exclusion of the evidence was proper." [Citation] (emphasis provided by Petitioner in her brief). Petitioner asserts that the Arbitrator allowed Respondent to proffer sufficient information concerning the nature of the evidence without tainting the Arbitrator's decision-making process by specifying the evidence Respondent sought to introduce.

The Commission agrees with the general proposition that the decision whether to reopen proofs is discretionary with the Arbitrator. The issue becomes whether the offer of proof Respondent was able to present adequately presented the Arbitrator with sufficient information to advise her on the exact nature of the evidence Respondent sought to introduce and whether it provided sufficient ability for Respondent to preserve its rights on review. Certainly, in the opinion of the Commission, offers of proof generally are much more specific and detailed than the one Respondent was permitted to provide in this case. Such offers precisely set forth what the proposed evidence would purportedly show.

The Commission recognizes that when a judge acts as the trier of fact, hearing evidence that is not admissible is generally not considered reversible error because the judge is presumed to be able to ignore any improper evidence and arrive at an appropriate decision without the decision-making process being tainted. This assumption does not apply when a jury acts as trier of fact because non-judicial laypeople are not considered to be as inclined to be able to ignore inadmissible evidence in arriving at an unbiased decision. The Commission also notes that Arbitrators and Commissioners now specifically and statutorily perform their duties pursuant to the Code of Judicial Conduct and are therefore placed in the same position as judges under Illinois law. *See*, 820 ILCS 305 §1.1.

In the opinion of the Commission the case would not have been tainted by a more detailed offer of proof because the Arbitrator is presumed to consider only competent evidence and should not be biased by hearing evidence that is deemed to be inadmissible. *See, Moran Transportation Corp. v. Stroger,* 303 Ill. App. 3d 459,472 (1st Dist. 1999). The Commission believes the evidence which Respondent sought to introduce could conceivably be relevant to the issues of Petitioner's credibility and/or causation to a current condition of ill being. The Commission concludes that the Arbitrator erred and should have allowed Respondent to go into greater detail in its offer of proof. Despite the Arbitrator's laudable desire to ensure she was able to arrive at an unbiased decision, she effectively denied Respondent's ability to adequately preserve its rights on review by significantly limiting its ability to present a detailed offer of proof.

Therefore, the Commission vacates the Decision of the Arbitrator and the award therein and remands the matter to the Arbitrator to allow Respondent to present a formal offer of proof specifically outlining the evidence it wants to introduce, after which the Arbitrator can decide whether or not to reconsider her denial of Respondent's Motion to Reopen Proofs. Thereafter, that decision may be the subject of further review by the Commission.

16IWCC0407

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated November 16, 2015 and the award therein is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that this matter be remanded to the Arbitrator for further proceedings consistent with this Decision including allowing Respondent to present a formal offer of proof.

DATED: JUN 16 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-6/7/16
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Hugo Alvarez,

Petitioner,

16IWCC0408

vs.

NO: 11 WC 08498

AMI Bearings,

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 and liability for medical treatment and expenses and being advised of the facts and law, 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 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).

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 258, 267 (1st Dist. 2011). The record shows that Petitioner underwent treatment that failed to provide demonstrable benefit. Petitioner testified that he simply placed himself in the hands of his doctors and followed their recommendations. This is not the standard for an award of medical expenses. We further note that any award of bills for services or treatment herein deemed compensable by the Commission

in this decision is subject to the fee schedule found in §8.2 of the Act. Pursuant to the Act, the employer must adjust the medical bills to conform to the fee schedule; the provider shall not require payment for any service at a rate greater than the lesser of the actual charge or the payment level set by the Commission. *Tiburzi Chiropractic v. Kline*, 2013 Ill App (4th) 121113.

The testimony of both Dr. Zindrick and Dr. Butler establishes that much of the treatment Petitioner had from April 2010 forward was excessive, lacked therapeutic value, and was not administered or performed in a way that provided any benefit. Beginning on the date of accident, November 10, 2009, Petitioner began a lengthy course of chiropractic treatment with Dr. Ruvarec. On April 28, 2010, Petitioner started receiving epidural injections and undergoing other invasive procedures performed by Dr. Abdellatif. Neither Dr. Butler nor Dr. Zindrick believed that Dr. Abdellatif's administration of multiple types of injections within a short span of time was advisable. By that method it was not reasonably discernable what, if any, effect a particular treatment had on Petitioner's condition. We modify the decision of the Arbitrator and deny the medical bills of Dr. Abdellatif. The evidence offered at arbitration did not demonstrate that continued treatments by Dr. Abdellatif were necessary to diagnose, relieve, or cure the effects of Petitioner's injury and therefore they should have been denied.

Furthermore, Petitioner failed to demonstrate that Dr. Ruvarec's chiropractic care after 2010 was reasonable and necessary. Petitioner treated with Dr. Ruvarec for over a year following the date of accident with no subjective or objective improvement. Petitioner testified that he had some relief during chiropractic therapy treatments but symptoms returned almost immediately after each session with Dr. Ruvarec. On October 12, 2010 Dr. Abdellatif referred Petitioner to a surgeon, Dr. Michael. Dr. Abdellatif acknowledged that Petitioner's condition was worsening, and despite all of the procedures he performed he had no further recommendations. As stated above, we find almost all of the treatment provided by Dr. Abdellatif, including additional epidural injections, radiofrequency ablations, sacroiliac joint injections, facet blocks, and an L4/5 and L3/4 percutaneous discectomy and decompression, was unnecessary. On October 25, 2010, Dr. Michael examined Petitioner and noted that it had been one year since Petitioner's injury and that he was not likely to improve without a lumbar fusion. The record fails to demonstrate the medical necessity for continued chiropractic treatment leading up to the October 21, 2011 fusion where such treatment was not justified by actual improvement in Petitioner's condition. We modify the decision of the Arbitrator to deny any further chiropractic treatment after the end of 2010.

We affirm the Arbitrator's decision to award the November 23, 2010 discogram and October 21, 2011 fusion surgery performed by Dr. Michael pursuant to §8(a) and §8.2. The Arbitrator relied on Dr. Zindrick's testimony that a lumbar fusion was warranted. Dr. Zindrick noted that Petitioner had a competent and consistent history of injury, failed conservative treatment, had a positive discography at L3/4 and L4/5 and was a surgical candidate, and reported improvement post-operatively. Further relying on the opinion of Dr. Zindrick, the Arbitrator found that it was not reasonable or necessary for Dr. Michael to perform any procedures other than the November 23, 2010 discogram before proceeding with the fusion

surgery. Accordingly, we affirm the decision of the Arbitrator to deny all treatment by Dr. Michael other than the initial discogram and the fusion surgery. The charges for the L4-5 posterolateral discectomy and L4-5 electrothermal therapy performed on December 26, 2010, the L4-5 discogram and biacuplasty performed on March 1, 2011, and the additional discogram performed on July 5, 2011 were denied by the Arbitrator, as were the expenses of 900 North Michigan Surgery Center from August 7, 2012 through September 18, 2012 for additional injections. However, we modify the decision of the Arbitrator to award payment of the OPTech bills for necessary post-operative bracing following Petitioner's lumbar fusion with hardware and allograft.

Finally, the Arbitrator deferred ruling on a $232,847.00 charge for "Supply Implants" at MetroSouth Medical Center for a later hearing on the reasonableness of the charge and a medical fee schedule analysis. We modify the decision of the Arbitrator to award the bill subject to the fee schedule; application of the fee schedule will adjust charges for the surgical hardware and allograft bone implant to no more than the scheduled amount pursuant to §8.2.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator dated March 19, 2015 is modified as stated herein and otherwise affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the diagnostic hardware injections and, if necessary, the hardware removal, as Petitioner's new treating physician, Dr. Zindrick, has recommended.

IT IS FURTHER ORDERED BY THE COMMISSION that the expenses for all services by Dr. Ossama Abdellatif and Chicagoland Advanced Pain & Headache Clinic from April 28, 2010 through April 27, 2011 are denied on the basis that they were not medically necessary.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for the following expenses for services rendered to Petitioner on account of the November 10, 2009 accident:

Expenses for services provided by Nicholas Ruvarec, D.C. and Accident Sports & Family Care for chiropractic treatment from November 10, 2009 through December 21, 2010, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of Dr. Ricardo Perez and Perez Health Inc. from March 16, 2010, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of Hind General Hospital for the November 23, 2010 discogram, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of Dr. Ronald Michael and Illinois Neurospine Institute related to the lumbar discogram on November 23, 2010 and the lumbar fusion surgery on October 21, 2011, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of Daniel Fortuna, D.C. from January 25, 2012 through October 19, 2012, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of BI Anesthesia, LLC on October 21, 2011 for anesthesia services, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of UniMed, Ltd. from October 21, 2011 through October 23, 2011 for the x-ray of the lumbar spine and CT angiography following the fusion surgery, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of Heart Care Centers of Illinois from October 10, 2011 through October 22, 2011 for EKG interpretation and vein imaging, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of American MRI, Inc. on December 24, 2009, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of OPTech on December 28, 2010 and October 11, 2011 for the post-fusion brace, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of MetroCenter for Health on October 22, 2011 and October 24, 2011 for care provided by infectious disease consultants, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of EBI, LLC on October 31, 2011 for the bone stimulator that Dr. Michael recommended post-operatively, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of Pathology Association of Chicago from October 10, 2011 through October 25, 2011 for the blood work done before, on and shortly after the fusion surgery, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of Equity Medical Services for related prescription medications from October 26, 2010 through October 30, 2012, pursuant to §8(a) and §8.2 of the Act.

Expenses for the services of MetroSouth Medical Center from October 10, 2011 through October 25, 2011 for the pre-operative work-up, surgery and in-patient care related to the lumbar fusion, pursuant to §8(a) and §8.2 of the Act.

16IWCC0408

Expenses of Dr. Michael Zindrick on November 6, 2012 for his evaluation of Petitioner, pursuant to §8 and §8.2 of the Act.

Expenses of Archer Open MRI on January 31, 2014 for the CT scan of Petitioner's lumbar spine that was ordered by Dr. Zindrick, pursuant to §8(a) and §8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000. The party commencing 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: JUN 16 2016
RWW/plv
o-04/27/16
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

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

16IWCC0408

ALVAREZ, HUGO
Employee/Petitioner

Case# **11WC008498**

AMI BEARING
Employer/Respondent

On 3/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC, LTD
MARK CONNOLLY
30 N LASALLE ST SUITE 2126
CHICAGO, IL 60602

2837 LAW OFFICES JOSEPH MARCINIAK
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2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

16IWCC0408

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)

HUGO ALVAREZ
Employee/Petitioner

v.

AMI BEARINGS
Employer/Respondent

Case # 11 WC 08498

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 **Chicago**, on **April 9, 2014** and **May 6, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **November 10, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,208.00**; the average weekly wage was **$504.00**.

On the date of accident, Petitioner was **35** 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 **$28,904.28** for TTD, **$0** for TPD, **$0** for maintenance, **$4,538.40** for PPD (3% MAW advance), and **$20,554.85** for other (medical) benefits, for a total credit of **$53,997.53**.

Respondent is entitled to a credit of **$21,458.36** under Section 8(j) of the Act.

ORDER

Medical Expenses

Pursuant to Section 8(a) and subject to Section 8.2 of the Act, Respondent shall pay the medical bills in the amount of **$373,044.35** for the reasonable, necessary and related medical care that has been provided to Petitioner. Respondent is entitled to a credit for amounts previously paid. The Arbitrator defers his ruling to a later hearing on the reasonableness of the $232,847.00 charge for "SUPPLY/ IMPLANTS" by MetroSouth Medical Center.

Prospective medical care

Respondent shall authorize and pay for the diagnostic hardware injections and, if necessary, the hardware removal, as Dr. Zindrick has recommended.

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

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

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

Signature of Arbitrator

March 3, 2015
Date

MAR 5 - 2015

I. Findings of Fact.

Petitioner testified with the aid of an interpreter.

Petitioner has been employed by Respondent for approximately 12 years and currently works in the position of Assembler. He testified that before November 10, 2009, the condition of his back was "fine" and that he was not seeking any treatment for his back.

Petitioner sustained an undisputed work accident on November 10, 2009.

Petitioner testified that at about 9:30 a.m., he was pulling, from a shelf, pieces wood that weighed over 35 pounds each when some of the pieces started to fall. He twisted his body, scraped his elbow and felt his back "snap." He immediately noticed pain in his low back. He reported the accident to his supervisor, Mike Nolan, who asked him if he wanted to see a doctor. At that time, both his back and his legs were hurting him. Petitioner initially declined medical attention and continued to work until noon or 1:00 p.m. that day. Since his pain had increased, Petitioner asked his supervisor if he could leave to see a doctor.

Petitioner sought chiropractic care from Dr. Nicholas Ruvarac, a chiropractor, on the date of accident. He chose Dr. Ruvarac on his own. Dr. Ruvarac's office note reflects Petitioner's stated history of working with a thirty-pound "housing" resting on a wood plank that tipped over. *PX1, page 1.* While bracing the plank in order to avoid losing control of the housing, Petitioner twisted and felt immediate pain in his low back. Petitioner complained of pain that radiated from the lower back to his right lower extremity and also on the left at times. He reported having right posterior thigh pain. Upon examining Petitioner, Dr. Ruvarac found, *inter alia*, moderate to severe spasm and tenderness in the sacroiliac area on the right. He also found that Kemp's test was positive bilaterally, supine straight leg raise was positive at 60 degrees on the right and resisted testing of the right gluteus maximus revealed weakness. Dr. Ruvarac's assessed Petitioner with lumbar sprain/strain, lumbar facet syndrome and sacroiliac sprain. *PX1, page 1.* Dr. Ruvarac's second diagnosis was knee sprain/strain and thoracic sprain/strain. He wrote that if Petitioner did not show significant progress in four to six weeks, the Dr. Ruvarac would order an MRI to rule out a lumbar disc. *PX1, page 1.*

Petitioner testified that Dr. Ruvarac restricted him to light-duty work, which Respondent accommodated.

Petitioner continued to treat with Dr. Ruvarac. Petitioner complained to Dr. Ruvarac that at times his back and leg pain improves, but then after work the pain is worse again. Petitioner stated that the treatment has helped him to continue to perform his duties. Dr. Ruvarac administered chiropractic modalities. *PX1, pages 2 through 6.*

On December 22, 2009, Dr. Ruvarac saw Petitioner. Petitioner complained of a lot of pain and discomfort. Upon examining Petitioner, Dr. Ruvarac noted moderate to severe spasm and tenderness in the lumbar region bilaterally, in the lumbo-sacral region bilaterally and in the gluteus major bilaterally. Dr. Ruvarac found that Kemp's, Braggard's, and straight leg raise tests were all positive on both sides. *PX1, page 7.* Dr. Ruvarac ordered an MRI.

Dr. John A. Aikenhead, a chiropractic radiologist, offered the following impression of the images taken on December 24, 2009:

(1) L4-L5, broad-based protrusion, left central to left foraminal regions.

(2) L3-L4, left foraminal protrusion with an annular tear is noted.

Dr. Ruvarac referred Petitioner to Dr. Xavier Pereja, Pain Management Specialist, at Instant Care. *PX3, page 49.*

Petitioner saw Dr. Pareja on April 20, 2010 for an evaluation. *PX3, pages 49-50.* Dr. Pareja noted a consistent history of accident, as well as Petitioner's complaint that chiropractic care was not helping. Petitioner complained of almost constant aching and stabbing pain in his low back that he rated at 8/10, and of occasional radiation of pain into his right leg along the posterior aspect as far down as the knee. It was severe, worsened with prolonged sitting as well as bending forward or lifting. Petitioner told Dr. Pareja that for the last 3-4 days, he has experienced a numbing sensation while walking. Dr. Pareja noted that Petitioner's sleep has been difficult secondary to pain. *PX3, pages 49.* Dr. Pareja wrote: "The pain appears to be discogenic accompanied by right-sided radicular symptoms." Dr. Pareja stated that Petitioner has no history of lower back pain prior to his accident and causally related Petitioner's condition and associated symptoms with the reported mechanism of injury. Dr. Pareja prescribed Gabapentin and a Lidoderm patch.

Dr. Pareja also ordered 2 epidural steroid injections, which were certified as medically necessary and appropriate by Respondent's utilization review nurse. *RX3.*

Petitioner testified that he declined to follow up with Dr. Pareja because his office was "very anti-hygienic."

According to Petitioner, Dr. Ruvarac next referred him to a "Dr. Hassan" at Grand Avenue Surgery Center, where he treated for four months. Although Dr. Ruvarac's note of May 4, 2010 corroborates Petitioner's testimony, the response to a medical records subpoena issued to Grand Avenue Surgery Center contains records of Dr. Ossama Abdellatif of Proclinics Chicagoland Advanced Pain & Headache Clinic. *PX1, page 11; PX4; PX4A.* None of Dr. Abdellatif's records identify a "Dr. Hassan."

Petitioner testified that when he saw "Dr. Hassan," his pain was intense and was worsening day by day.

Dr. Abdellatif first examined Petitioner on April 27, 2010. *PX4, page 75.* No history of an accident is documented anywhere in his records. Petitioner complained of low back and right leg pain. On examination, Petitioner exhibited decreased range of motion of the lumbar spine and complained of tenderness at the bilateral sacroiliac joint. *PX4, page 78.* Dr. Abdellatif ordered an EMG, an epidural steroid injection, and physical therapy. *PX4, page 80.*

On April 28, 2010, Dr. Abdellatif administered a lumbar epidural steroid injection to the area near the L4-L5 disc, lumbar blocks from L3-L4 through S1, and a trigger point injection. *PX4, pages 69-74.* Petitioner was noted to have shown a good response with no new complaints or complications on May 4, 2010. *PX4, page 81.*

On May 12, 2010, Dr. Abdellatif repeated the same procedures. *PX4, pages 107-112.* Petitioner again was noted to have shown a good response with no new complaints or complications on May 16, 2010. *PX4, page 85.*

On May 26, 2010, Dr. Abdellatif repeated the same procedures and performed a "facet neurolysis" at multiple levels of Petitioner's spine. *PX4, pages 90-95.* At a follow up exam on June 1, 2010, Petitioner complained of pain radiating down both legs, and he reported feeling uncomfortable sitting and standing. *PX4, page 96.* Dr. Abdellatif also noted multiple tender points in the upper and middle back. He referred Petitioner to Dr. Fortuna, another chiropractor, for aqua therapy.

On June 9, 2010, Dr. Abdellatif administered another lumbar epidural steroid injection to the L4-L5 disc, more blocks, and another "facet neurolysis" to the same levels. *PX4, pages 100-105.* On June 22, 2010, the doctor noted that Petitioner's pain was "discogenic in nature with occasional lumbar radiculopathy." *PX4, page 113.* On June 23, 2010, Dr. Abdellatif administered yet another lumbar epidural steroid injection to the L4-L5 disc and another trigger

point injection. He also performed a discogram that showed concordant pain at L4-L5 and L5-S1. *PX4, pages 117-123.* He recommended a disc decompression procedure.

Respondent submitted Dr. Abdellatif's request for a third lumbar epidural injection to utilization review. *RX4.* Terrence Wilson, M.D., the reviewing physician, recommended non-certification based on an absence of objective signs of nerve root irritation. His report is dated June 29, 2010.

Petitioner returned to Dr. Ruvarac on July 1, 2010 and reported that treatments with "Dr. Hassan" were not helping. *PX1, page 12.* Dr. Ruvarac continued to provide chiropractic care consisting of manipulations and passive modalities.

On July 28, 2010, Dr. Abdellatif administered another lumbar epidural steroid injection to the L4-L5 disc and performed another discogram that showed findings identical to those on June 23, 2010. *PX4, pages 141-144.* He also performed a discectomy of the L4-L5 disc and administered another trigger point injection. *PX4, pages 138-140.* Petitioner testified that "a number of injections" only helped for about a week, and that his pain remained unchanged after the decompression.

Respondent scheduled the first of four Section 12 examinations with Dr. Jesse Butler for September 16, 2010. Dr. Butler opined that Petitioner sustained a lumbar strain as a result of the work accident. He found no specific objective neurological deficits. He further opined that Petitioner had reached a plateau, but could not state whether he had reached MMI because he did not have all of the records. *RX1, page 12.* He agreed that Petitioner could work with a 30-pound restriction.

Petitioner testified that Dr. Ruvarac next referred him to Dr. Ronald Michael of Illinois Neurospine Institute. This is not borne out by Dr. Ruvarac's records. *PX1.* It is borne out by Dr. Michael's first report dated October 10, 2010. Three days later, Dr. Michael gave him two choices: learn to live with the pain and accept it or alternatively he may consider surgery. *PX5, page 27.*

Over the course of the next year, Dr. Michael performed four discograms, an IDET, and a discectomy/biacuplasty. *PX5, PX7.* Respondent submitted Dr. Michael's requests for a repeat discogram and a discectomy/biacuplasty to utilization review. *RX5, RX6.* The procedures were non-certified because the utilization reviewer found nothing that was definitely, objectively abnormal on the neurological examination and no evidence of a surgical lesion on imaging studies. *RX5, RX6.* Dr. Robert Winans, the reviewing physician, indicated in his reports that he

made multiple attempts to reach Dr. Michael for a peer-to-peer discussion, but was unsuccessful. *RX5, RX6.* Petitioner testified that none of these procedures provided any lasting relief.

Dr. Butler examined Petitioner again on May 12, 2011. This time he was provided with records of Petitioner's treatment, including those of Dr. Abdellatif and Dr. Michael. *RX1, pages 14-16.* He opined that Petitioner was somewhat worse after Dr. Abdellatif's disc decompression. *RX1, page 16.* He opined that he would not have ordered these procedures because they do not work. *RX1, page 22.* One discogram was all that should have been done. *RX1, page 26.*

Petitioner testified that he had pain in both legs before surgery. He was unable to tolerate the pain, and was "unable to do anything." Petitioner's son was born during this time, and Petitioner felt "useless" even though he continued to work light duty for Respondent until the surgery.

On October 21, 2011, Dr. Michael performed, on Petitioner, lumbar fusion surgery at L3-4 and L4-5. *PX5, PX7.*

Petitioner testified that after the surgery, the pain in his left leg disappeared, the pain in his right leg diminished, and the pain in his back pain diminished a little, but never went away.

After surgery, Petitioner underwent chiropractic therapy with Dr. Fortuna. He continued treating with Dr. Michael, and received more injections ten months after surgery.

By agreement with Respondent, Petitioner consulted Dr. Zindrick initially on November 6, 2012. Petitioner rated his pain level at between six and nine on a scale of ten. Dr. Zindrick reviewed the extensive medical records and commented that he did not agree with much of the failed conservative care Petitioner had before he underwent a fusion. *PX9.* His impression was that Petitioner sustained disc injuries at L3-4 and L4-5 as a result of the work accident in October 2009. He testified that the MRI findings of December 24, 2009 and the positive finding at L4-5 on the discogram of November 23, 2010 confirmed that Petitioner was a surgical candidate. He would have recommended a fusion, but no more than one discogram, and no biacuplasty and no IDET because such procedures are not effective. *PX1, pages 17, 21, 23-24.*

Petitioner seeks an award of medical expenses in the amount of $962,478.43, of which he claims $771,884.06 remains unpaid. *PX14.*

II. Conclusions of Law

In support of his decision relating to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator makes the following conclusions of law:

It is undisputed that Petitioner sustained an accidental work injury when he twisted his low back on November 10, 2009. Petitioner chose to pursue chiropractic care, which provided some relief. *PX1.*

A December 24, 2009 MRI of Petitioner's lumbar spine was interpreted as showing: (1) L4-5, broad-based protrusion, left central to left foraminal regions, and (2) L3-L4, left foraminal protrusion with an annular tear.

On April 20, 2010, Dr. Pareja stated that Petitioner has no history of lower back pain prior to his accident and causally related Petitioner's condition and associated symptoms with the reported mechanism of injury. Dr. Pareja wrote: "The pain appears to be discogenic accompanied by right-sided radicular symptoms." *PX3, page 50.* Indeed, Dr. Pareja ordered bilateral epidural steroid injections at L3-4 and L4-5. *PX3.* Respondent's utilization review of May 5, 2010 certified the two injections. *RX3.*

Dr. Butler, in his September 16, 2010 examination report, diagnosed Petitioner with a lumbar strain, and in his May 12, 2011 examination report, diagnosed Petitioner with lumbar degenerative disc disease and lumbar strain. *RX1, Deposition Exhibits.*

Both Dr. Butler and Dr. Zindrick agreed that lumbar injections were a reasonable course of treatment. *PX13, page 28; RX1, page 20.*

Dr. Butler testified that Petitioner's current condition of ill-being *is not* causally related to the November 10, 2009 accident and Dr. Zindrick testified that Petitioner's current condition of ill-being *is* causally related to the November 10, 2009 accident

Both Dr. Butler and Dr. Zindrick point out that Dr. Abdellatif's "unorthodox" approach—administering multiple types of injections in conjunction with discograms—defeated the purpose of injections, which is to identify the source of pain. *PX13, page 28; RX1, pages 20-21.* Moreover, the close period of time in which Dr. Abdellatif administered the injections was neither reasonable nor necessary since not enough time had elapsed to discover the response from the first injection. *PX13, page 33.* Dr. Abdellatif performed the first of two "facet neurolyses" on May 26, 2010. The notes of the very next office visit confirm that Petitioner's complaints worsened after that procedure—and continued to worsen. Dr. Michael's preoperative

course of multiple discograms with biacuplasty and IDETs failed to provide any relief to Petitioner.

Dr. Butler, Respondent's Section 12 physician, opined that the cumulative effect of these multiple procedures, particularly the decompression, caused an iatrogenic injury to Petitioner's L4-5 disc. *RX1, pages 23-24, 32.*

On January 15, 2014, Dr. Butler testified to the following:

Q: Just so it's clear, are you saying this is a cumulative type injury or did one of the procedures specifically cause it?

A: Well, I think they're all in different levels of injury to the disc.

Q: Okay.

A: There's a Dr. Caragee, C-A-R-A-G-E-E from Stanford who's written extensively on the detrimental effects of discography to the spine, and he's shown on patients that have had discograms, on follow-up MRIs down the road, you actually see changes on the MRIs that result from having a needle stuck in the disc and that disc pressurized. So every time you do a procedure on a disc, there is an injury to it. The percutaneous disc decompression, if that had been performed, and again, I don't have an operative report to say whether it was, would probably have been the most damaging because you actually go in and coagulate and suck out a bunch of disc. The IDET procedure has been shown to be a sham procedure, and that putting that hot copper wire into the disc in a theoretical attempt to shrink the annulus, so only maybe 10 percent of the disc is actually impacted by an IDET procedure. But, nonetheless, you're putting a trocar into the disc and shoving a hot copper wire around it. The biacuplasty uses a radiofrequency probe from both sides into the disc, so again you're puncturing the posterior annulus and subjecting it to a radiofrequency signal that theoretically tightens, shrinks the annulus. Again, it's been shown to really not be an appropriate procedure either. So these are three procedures on the disc in a short period of time that - - actually five procedures in a short period of time because Abdellatif did discograms before, they all have a cumulative impact on the disc. *RX1, pages 25-26*

On December 9, 2013, Dr. Zindrick, Petitioner's current treating physician, testified to the following:

Q: Doctor, I'd like to ask you some questions, and I'm going to ask your opinion based upon a reasonable degree of medical and surgical certainty. You testified before that you did review Mr. Alvarez's records in detail, and you commented on the same in your report. Now, you've previously given the opinion in your notes that his current condition is causally related to his November 10, 2009 work accident, is that correct?

A: That's correct.

Q: And you've also reviewed Dr. Butler's reports that have been done in this case, correct?

A: That's correct.

Q: And at this time, am I correct that you and Dr. Butler both have the same opinion as far as what treatment needs to occur going forward?

A: That's my understanding, yes.

Q: And Dr. Butler did not believe that Mr. Alvarez's fusion was reasonable and necessary, correct?

A: That was his opinion, yes.

Q: Do you believe based upon a reasonable degree of medical and surgical certainty that the lumbar fusion that Mr. Alvarez received was reasonable and necessary?

A: I do. *PX13, pages 12-13.*

*****

Q: When you decide to do a fusion, what do you base that on as far as the pain complaints, diagnostics, et cetera? What do you like to see overall before you jump to that? Or not jump to that, but before you go to a fusion.

A: If the patient needs to have - - There has to be an appropriate length of time between the injury and the recommendation for fusion. Some would argue that's somewhere between six months and a year. Mr. Alvarez was, at the time I would have thought he was a surgical candidate, was coming up on a year. He had failed conservative care, he had demonstrated abnormalities at two discs, and those appeared to be the source of his pain. And his options at that point are to live with it or consider surgical intervention, and I think that that point was reached about a year after his injury. *PX13, pages 17-18.*

It is true that Petitioner was not given a surgical recommendation before he started treating with Dr. Abdellatif. However, Petitioner had failed six months of chiropractic care and later underwent lumbar fusion surgery at the levels indicated on the December 24, 2009 lumbar MRI. Furthermore, Dr. Zindrick testified that he did not see any evidence in the records that would suggest Dr. Abdellatif's treatment caused the disc injury.

Section 19(e) of the Act states, in pertinent part, the following:

> "Decisions rendered by the Commission and dissents, if any, shall be published together by the Commission. The conclusions of law set out in such decisions shall be regarded as precedents by arbitrators for the purpose of achieving a more uniform administration of this Act."

Respondent argues that the facts of this case are similar to those in David Fenwick v. Area Wide Septic, 07 IWCC 0769. In Fenwick, the Commission found that four discograms and a fusion surgery were unreasonable and unnecessary to cure claimant's work-related low back injury and thus were not causally related to the work accident.

The Arbitrator finds that the facts in Fenwick are distinguishable from the case at bar.

In Fenwick, claimant sustained a work-related lumbar injury on June 18, 2003, after which he experienced low back pain. Ten days after such injury, claimant's family physician released him to light-duty work. Approximately three months after the work-related injury, on September 15, 2003, Dr. DePhillipps wrote: "The patient has been working which does not seem to be aggravating his pain and therefore, I suggested that he remain working unless his pain worsens." On October 6, 2003, claimant received a lumbar epidural steroid injection that clearly worsened his condition. Not only did such injection result in a severe aggravation of low back pain, it brought about radiating pain into both legs, as well as intermittent numbness and tingling in both legs, right greater than left, and occasional weakness in the right leg. Subsequently, claimant underwent four discograms followed by a two-level fusion surgery. Post-operatively, claimant did well but then his pain progressively worsened. Eight months after the fusion surgery, claimant voiced complaints of severe pain in the low back, shooting pain into the left lower extremity and numbness in the right lower extremity. Claimant indicated that he had difficulty ambulating, even with a walker and a brace.

In the case at bar, on the date of accident, Petitioner complained not only of low back pain but also of bilateral leg pain. Furthermore, Petitioner testified that the procedures that Dr. Abdelltarif performed did not make him worse but rather did not resolve his pain. In Dr. Ruvarac's office notes of July 27, 2010, which was one day before Dr. Abdelltarif performed the percutaneous disc decompression, Dr. Ruvarac noted that Mr. Alvarez's low back and leg pain remained unchanged. Then, three days after the percutaneous disc decompression, Dr. Ruvarac wrote the same thing. Specifically, on July 31, 2010, Dr. Ruvarac wrote: "Mr. Alvarez stated that since the last visit, his low back and leg pain have remained unchanged." On August 12, 2010, he once again indicated that his low back and leg pain remained unchanged. On August 16, 2010, Mr. Alvarez indicated his low back pain and leg pain have been worse due to work. On August 19, 2010, Mr. Alvarez stated that since the last visit, his low back and leg pain have gotten better. *PX1.*

Dr. Abdelltarif's records following this procedure actually indicate improvement in Petitioner's condition. His August 3, 2010 note states: "Patient has shown 70% improvement to percutaneous disc decompression." *PX4, page 65.* His August 17, 2010 note states: "... no new complaints no complications after disc decompression." *PX4, page 69.*

Dr. Michaels's June 6, 2011 office note includes the following: "Regrettably, he has not improved after his disc decompression and his biacuplasty at L4-L5. Indeed, over the past week he reported severe low back pain and cramping. In addition, he fell due to the pain." *PX5, page 21.*

Petitioner testified that he feels better than he did before he underwent the two-level fusion surgery. He testified that after the surgery, the pain in his left leg disappeared, the pain in his right leg diminished, and the pain in his back diminished a little, but never went away. After the fusion surgery, Petitioner testified, he was able to stand up, sit down and sleep better and, overall, found that such surgery improved his quality of life.

Dr. Zindrick testified that Petitioner told him that he was 40% to 50% better after the fusion surgery.

On cross-examination, Petitioner testified that in July 2011, he was rear ended in a motor vehicle accident. Petitioner testified that he was stopped at a stoplight and that the other driver was going slowly and just "touched" his car from behind. Petitioner denied that he injured his low back in such motor vehicle accident. Yet, in Dr. Michael's August 15, 2011 office notes, he wrote: "The patient was involved in a motor vehicle accident on July 29, 2011. This was a rear-

end collision. His low back was aggravated significantly. He reports that his low back pain was severe." *PX5, page 18.* Petitioner testified that such office note is incorrect.

As Petitioner was undergoing treatment at the time of the motor vehicle accident, he had discussed fusion surgery as an option, and his back was in a weakened condition, the Arbitrator finds that Petitioner did not sustain an intervening accident. Please see Vogel v. Illinois Workers' Comp. Comm'n, 821 N.E.2d 807, 290 Ill. Dec. 495 (2d Dist. 2005)

With regard to the issue of causation, the Arbitrator finds the opinions of Dr. Zindrick to be more persuasive than those of Dr. Butler.

Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accident of November 10, 2009.

In support of his decision relating to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator makes the following conclusions of law:

Based upon his finding that Petitioner's current condition of ill-being is causally related to the work accident of November 10, 2009, the Arbitrator awards a portion of the medical care/medical bills.

The Arbitrator has carefully considered the evidence, especially the opinions of Dr. Zindrick and Dr. Butler. Dr. Zindrick testified that the total of the bills "seems very excessive." Blue Cross/Blue Shield of Illinois, Petitioner's group insurance carrier, has paid some of the bills. The Arbitrator also considers the opinions of the utilization reviewers.

The Arbitrator awards, pursuant to Section 8(a) and subject to Section 8.2, the following:

The charges for chiropractic treatment provided by Nicholas Ruvarac, D.C. [DOS 11/10/2009 – 1/29/2011 and 2/5/2011 – 10/20/2011] in the amount of $23,116.00 (*PX14, Item1, PX1*)

The charges for the office visits to Dr. Ossama Abdelltarif on April 27, 2010, April 28, 2010, May 4, 2010, May 12 and May 18, 2010, as well as the injections/other services provided by the doctor on April 28, 2010 and May 12, 2010 [DOS 4/27/2010, DOS 4/28/2010, DOS 5/4/2010, DOS 5/12/2010, DOS 5/18/2010] in the amount of $8,281.11 (*PX14, within the supporting records for Item 3, PX4*)

The April 28, 2010 and May 12, 2010 charges for the facility fees, other radiology, recovery room and anesthesia at Grand Avenue Surgical Center [DOS 4/28/2010 and DOS 5/12/2010] for a total amount of $45,067.00 (*PX14, within the supporting records for Item 12, PX4a*)

The charges for the first discogram that Dr. Michael performed [DOS 11/23/2010] in the amount of $15,348.90 and the charges for the two-level lumbar fusion surgery that Dr. Michael performed [DOS 10/21/2011] in the amount of $175,150.81 (*PX14, within the supporting records for Item 4, PX5*) Dr. Zindrick opined that the only procedures that he would have done were the November 23, 2010 discogram and the October 21, 2011 laminectomy/fusion. Dr. Zindrick also opined that he knows of no other reason for one to "unbundle" a procedure than to get more money for the same procedure. Petitioner's Exhibit 13, Deposition Exhibit #4, indicates the amount that Dr. Zindrick would charge for the same two-level fusion surgery that Dr. Michael performed on Petitioner: $57,368.00. Yet Dr. Michael's charges, as with all the medical bills submitted in this case, are subject to the Illinois Medical Fee Schedule.

The charges of Hind General Hospital for DOS 11/23/2010 related to the discogram in the amount of $13,768.10 (*PX14, supporting records for Item 5, PX6*)

The charges of Daniel Fortuna, D.C., from DOS 1/25/2012 – 10/19/2012 in the amount of $11,853.84 (*PX14, within the supporting records for Item 6, PX8*) The Arbitrator notes that Dr. Ruvarac was already providing chiropractic services in the years 2010 and 2011.

The charges of BI Anesthesia, LLC, for DOS 10/21/2011 for anesthesia services provided to Petitioner just prior to the fusion surgery in the amount of $5,100.00. (*PX14, Item 7, PX7*)

The charges of Unimed, Ltd., for DOS 10/21/2011-10/23/2011, for the x-ray of the lumbar spine and CT angiography following the fusion surgery, in the amount of $450.00. (*PX14, Item 8, PX7*)

The charges of Heart Care Centers of Illinois for DOS 10/10/2011, 10/22/2011 and 10/24/2011 for EKG interpretation and vein imaging, in the amount of $315.00 (*PX14, Item 9, PX7*)

The charges of American MRI, Inc., for the MR images of Petitioner's lumbar spine [DOS 12/24/2009] in the amount of $1,700.00 (*PX14, Item 10, PX3*)

The charges of Metro Center for Health for DOS 10/22/2011 – 10/25/2011 for care provided by infectious disease consultants in the amount of $1,140.00. (*PX14, Item 13, PX7*)

The charges of EBI, LLC, for the bone stimulator that Dr. Michael recommended post-operatively [DOS 10/31/2011] in the amount of $5,948.90. (*PX14, Item 14, PX5*)

The charges of Pathology Association of Chicago for the blood work done before, on and shortly after the fusion surgery [DOS 10/10/11-10/23/11] in the amount of $1,493.00. (*PX14, Item 15*)

The charges of Equity Medical Services for prescription medication by mail [DOS 10/26/10-10/30/12] in the amount of $9,933.94 (*PX14, Item 16, PX5*)

A portion of the charges of MetroSouth Medical Center for the pre-operative work-up (ECG), surgery and in-patient care in the amount of $51,525.75 [DOS 10/10/2011-10/25/2011] (*PX13, Item 17, PX7*) The Arbitrator defers his ruling to a later hearing on the reasonableness of the $232,847.00 charge for "SUPPLY/IMPLANTS." The Arbitrator would like the charge broken down and a medical fee schedule analysis conducted of this $232,847.00 charge.

The charges of Dr. Michael Zindrick, Petitioner's new treating physician, for his evaluation of Petitioner and his report [DOS 11/6/2012] in the amount of $1,252.00 (*PX14, Item 18, PX13*)

The charges of Archer Open MRI for the CT scan of Petitioner's lumbar spine [DOS 1/31/2014] that Dr. Zindrick ordered, in the amount of $1,600.00. (*PX13, Item 19, PX12*) With regard to the $380.00 bill from Dr. Perez, the Arbitrator denies it since the bill is not supported by office notes for DOS 3/16/2010 and 3/30/2010. (*PX2*)

With regard to the charges by OPTech in the amount of $3,111.87, the Arbitrator denies these charges. Although Health Insurance Claim Forms indicate that Dr. Michael ordered these products, there is no indication in Dr. Michael's treating notes that he ordered any type of brace or prosthetic or other device. There was no testimony by Petitioner that he used a brace or prosthetic or other device.

With regard to the charges by 900 North Michigan Surgery Center in the amount of $13,001.36, the Arbitrator denies these charges since Dr. Zindrick opined that the only procedures that he would have done were the November 23, 2010 discogram and the October 21, 2011 laminectomy/fusion.

In support of his decision relating to issue (N) "Is Respondent due any credit?", the Arbitrator makes the following conclusions of law:

Petitioner testified that Respondent provides group medical insurance. The parties stipulated to a credit of $21,458.36 under Section 8(j).

In support of his decision relating to issue (K) "Is Petitioner entitled to any prospective medical care?", the Arbitrator makes the following conclusions of law:

Based upon his finding that Petitioner's current condition of ill-being is causally related to the work accident of November 10, 2009, the Arbitrator awards the prospective medical care that Dr. Zindrick has recommended.

In the December 9, 2013 deposition of Dr. Zindrick, he testified to the following:

Q: And then he [Petitioner] saw you roughly about five weeks later on July 17th, 2013?

A: Yes.

Q: And he indicated on that date his leg pain was markedly better compared to prior to surgery?

A: His leg pain, yes.

Q: And - -

A: But he was still having pain at this point. That was his major complaint.

Q: Now, at that time you had recommended diagnostic hardware injections?

A: Well, he was having some ongoing back pain with increased activity, and flexion and extension x-rays were - - previous x-rays had showed all the instrumentation in his back and he was having tenderness over the midline and the area of his fusion where the hardware was, so at this point we recommended some injections because it was possible as he was getting back to work and increasing his activity, he was getting inflammation and irritation from his hardware.

Q: So when you do those injections, what are you looking for?

A: Well, if the patient gets pain relief from the injections and it's substantial, that's great. We don't have anything more. And if it's lasting. If it's temporary and we relieve the pain injecting around the metal, then that's a reasonable indicator that the metal is the source of the aggravation. And if the pain is significant and uncontrolled, removal of the hardware at that time would be a reasonable thing to do. We always inspect the fusion at that time as well, and if there is any defect or abnormality of the fusion, it would be repaired as well. Because sometimes a failed fusion can masquerade as painful hardware as well.

Q: And that was what you recommended at that time? You next saw him August 16, 2013?

A: Yes.

Q: And he had not undergone the injections yet at that point?

A: That was my understanding, yes. (Bracketed word added.) *PX13 , pages 9-11*

Based on the foregoing, and in accordance with Section 8(a) of the Act, the Arbitrator finds that Petitioner is entitled to the prospective medical care that Dr. Zindrick has recommended, specifically, diagnostic hardware injections and, if necessary, hardware removal.

In support of his decision relating to issue (M) "Should penalties or fees be imposed upon Respondent?", the Arbitrator makes the following conclusions of law:

Sections 16, 19(l), and 19(k) of the Act are intended to address situations in which there is not only a delay in the payment of benefits, but a delay that is deliberate or the result of bad faith or improper purpose. McMahan v. Industrial Commission, 183 Ill. 2d 499, 514-15 (Ill. 1998). Imposition of penalties/assessment of attorney's fees requires more than a lack of good and just cause. Id., at 515. An employer must make an intentional decision not to honor its statutory obligations to an employee. Id. Penalties under the Act are inappropriate when nonpayment of benefits is based on a reasonable and good faith challenge to liability. Ford Motor Co. v. Industrial Commission, 126 Ill. App. 3d 115 (1st Dist. 1984). Penalties are not ordinarily imposed when an employer acts in reliance on a qualified medical opinion. O'Neal Brothers Construction Co. v. Industrial Commission, 93 Ill. 2d 30, 41 (Ill. 1982), Pluto v. Industrial Commission, 272 Ill. App. 3d 722, 730 (1st Dist. 1995), Consolidated Freightways v. Industrial Commission, 136 Ill. App. 3d 630, 633 (3rd Dist. 1985).

The Arbitrator finds that Respondent had a reasonable basis for disputing liability for Petitioner's treatment. The medical evidence shows that much of Petitioner's treatment was questionable, duplicative, and ineffective. Respondent based their disputes to liability on the utilization reviews and the Section 12 exams conducted by Dr. Butler. Moreover, Dr. Zindrick's opinions echo many of those of Dr. Butler.

The Arbitrator finds that Respondent acted reasonably under the circumstances and denies Petitioner's request for penalties and attorney's fees.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEROY WATTS,

Petitioner,

16IWCC0409

vs.

NO: 14 WC 10644

PRAIRIE FARMS DAIRY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, and 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.

Based upon a review of the record as a whole, and taking into account the criteria and factors pursuant to Section 8.1b of the Act, the AMA impairment rating of 2% loss of use of the lower extremity or 1% man as a whole provided by Dr. Russo, Petitioner's return to work full duty as a box crew/stacker, Petitioner's age of 48, the lack of evidence of any impact on his ability to earn wages in the future, and the evidence of some disability contained within the medical records, the Commission modifies the Arbitrator's permanent partial disability award from 22.5% loss of use of the right leg to 15% loss of use of the right leg under Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 10, 2015, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

16IWCC0409

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $8,591.74 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is given a credit of $8,810.42 for temporary total disability benefits paid to date.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $498.82 per week for a period of 32.25 weeks, as provided in §8(e)2 of the Act, for the reason that the injuries sustained caused the permanent partial disability to the extent of 15% loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $7,492.63 under §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent 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 $17,300.00. 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: JUN 17 2016
KWL/kmt
06/07/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0409

WATTS, LEROY
Employee/Petitioner

Case# **14WC010644**

PRAIRIE FARMS DAIRY
Employer/Respondent

On 11/10/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
4242 N KNOXVILLE AVE
PEORIA, IL 61614

2396 KNAPP OHL & GREEN
L DAVID GREEN
PO BOX 446
EDWARDSVILLE, IL 62025

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

16IWCC0409

LEROY WATTS
Employee/Petitioner

v.

PRAIRIE FARMS DAIRY
Employer/Respondent

Case # 14 WC 10644

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 **PEORIA, ILLINOIS**, on **09/25/2015**. 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

16IWCC0409

On **11/30/2013**, 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 $**43,231.00**; the average weekly wage was $**831.37**.

On the date of accident, Petitioner was **48** 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 $**8,810.42** for TTD, $**-0-** for TPD, $**-0-** for maintenance, and $**-0-** for other benefits, for a total credit of $**8,810.42**.

Respondent is entitled to a credit of $**7,492.63** under Section 8(j) of the Act. Respondent shall keep Petitioner safe and harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to extent of such credit.

ORDER

Respondent shall pay reasonable and necessary medical services of $8,591.74, as provided in Section 8(a) of the Act. Said services are to be paid consistent with the medical fee schedule.

Respondent shall pay Petitioner permanent partial disability benefits of $**498.82**/week for 48.375 weeks, because the injuries sustained caused the 22-1/2% loss of **use of the right leg**, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

11/6/15
Date

NOV 10 2015

ATTACHMENT TO ARBITRATOR'S DECISION
(14 WC 10644)

STATEMENT OF FACTS:

Petitioner is a fifty (50) year old "box crew/stacker" or a warehouseman for Respondent, Prairie Farms, where he has worked continuously on a full time basis since December 2008. His job duties are to box-up gallon milk jugs, stack them, and load them into trucks.

According to Petitioner, on November 30, 2013 he was walking backwards in a cooler pulling a stack of milk when he slipped and fell forwards, striking his chest and his right knee. Petitioner gave immediate notice and a written "Incident Report" was completed which Petitioner wrote, "stacking gallons fell forward landing on chest and knee was injured." (PX 6)

Records submitted show Petitioner sought immediate medical attention, going to the Methodist Medical Center emergency room that night. (PX 4, pp.2-16) There, his history in the "Triage" portion of the records show, "Patient states that while at work he fell and now has pain to right knee. Patient states that he works at Prairie Farms." (p.3) In the "Clinician History of Present Illness" portion of the record it's noted, "...The patient states that this problem is job related...Injured in a fall...Lost balance and fell...Patient complains of pain over the right knee. Local soft tissue swelling over the right knee...Suffered a "twisting" knee injury. (p.4) An examination revealed mild to moderate swelling of the right knee. Petitioner was diagnosed with a sprain of the right knee. (p.5) Petitioner returned to regular duty work.

Petitioner was evaluated at IWIRC on January 10, 2014. (PX 3) He gave a history that on November 30, 2013 at 1:00 a.m. he was pulling a stack of milk out of the cooler, lost his footing, and fell forward striking his right knee on a crate and the floor. IWIRC diagnosed a right knee contusion/strain, ordered physical therapy, and allowed Petitioner to continue working with self-modifications to his job. (PX 3, p.2)

Petitioner returned to IWIRC on January 17, 2014 with continuing right knee complaints. It was noted he was working on regular duty work restrictions. Also noted was that physical therapy was pending authorization. By February 27, 2014, Petitioner reported that his right knee symptoms had not improved and that he thought the right knee was getting worse. The medical provider noted that Petitioner missed three office visits and refused to go to physical therapy since he "knows" it will not help. Physical therapy recommendation was continued and a MRI of the right knee to rule out ligamentous pathology was prescribed. (PX 3, p.5)

On March 4, 2014 it was recorded that Petitioner indicated his knee pain was getting worse. It was noted that neither the MRI nor the physical therapy had been performed as IWIRC continued to wait for authorization from Respondent's carrier. Petitioner was given activity restrictions of light duty with occasional lifting up to 20 pounds. (PX , p.7) Petitioner testified that he was not offered restricted duty and began receiving temporary total disability benefits.

On March 12, 2014, the right knee MRI was performed. (PX 5) The study demonstrated a horizontal tear of the body and posterior horn of the medial meniscus; diffuse chondromalacia, and a small joint effusion. On March 13, 2014, Petitioner was assessed with right knee medial meniscal tear and referred for an orthopedic consult at Midwest Orthopedic. (PX 3, p.9)

Petitioner initially saw Dr. Mike Gibbons on April 10, 2014. He gave a history of slipping and falling on a wet floor on November 30, 2013 while stacking boxes. Petitioner thought he twisted and landed on his right knee, but since the accident happened so fast, he was not 100% sure. Petitioner reported immediate medial pain in the knee and had subsequent swelling. Dr. Gibbons diagnosed Petitioner with a right knee medial meniscus

tear and mild medial compartment chondrosis. Dr. Gibbons concluded that conservative treatment had failed, and recommended right knee arthroscopy. (PX 2, pp. 60-61)

On May 23, 2014 Petitioner underwent surgical repair of his torn medial meniscus in the form 1.) right knee arthroscopy with partial medial meniscectomy; and 2.) chrondroplasty medial femoral condyle. (PX 2, pp.55-56) On June 2, 2014, Dr. Gibbons saw Petitioner post-operatively and recommended physical therapy "since he is a little behind as far as range of motion and overall rehab is concerned." (PX 2, p.25) On July 3rd, a physician's assistant saw Petitioner and kept him off work until July 14, 2014 so that he could complete his physical therapy. (PX 2, pp.10-11)

Petitioner testified that he did return to work, full duty, on July 14, 2014. He testified that initially upon returning to work he had knee pain and difficulty performing his job, but that his supervisor "worked with him."

Petitioner was evaluated at his attorney's request by Dr. Frank Russo on February 23, 2015. (PX 1, dep. p.7) His history to Dr. Russo was consistent with the prior medical records and his arbitration testimony. Dr. Russo opined that horizontal meniscus tears are more commonly associated with trauma. (dep. p.13) Dr. Russo testified that he reviewed all of the treatment records from Methodist Hospital, IWIRC, and Midwest Orthopedic. (dep. p.14) In his exam that day, Dr. Russo noted obvious swelling of the right knee (2 cm circumference greater than the uninjured left knee), tenderness in the medial compartment, limited range of motion with flexion in the right knee, and an altered gait with reduction of weight bearing on the right foot. (dep. p.18) Dr. Russo diagnosed Petitioner with right medial meniscus tear status post arthroscopic partial meniscectomy and a small chondral lesion of the right medial femoral condyle, status post chondroplasty. (dep. p.20)

Dr. Russo opined that the November 30, 2013 work accident caused the meniscal tear and either caused or aggravated the condylar condition. He also opined that the November 30, 2013 accident necessitated the surgery in May 2014. Dr. Russo did an impairment rating which yielded a 2% impairment to the lower extremity. (dep. pp. 21-23)

Petitioner denied any prior injuries to his right knee. He testified on direct that he had several other work-related injuries in the past 7 years but none involving his right knee. Records submitted show that he prepared an "Incident Report" claiming that he injured his right knee on November 23, 2013 when he "...was stacking gallons of HOMO and was walking backwards and fell with product." (RX 4, p.1) On November 25, 2014, Petitioner prepared an "Incident Report" indicating, "I was pulling stacks across the moving chains and slipped when putting product away. Kyle Henderson seen the incident and helped me off the floor on the chains." Petitioner indicated his right knee has "tightened up." (PX 6, p.2) On July 16, 2015, Petitioner reported a work injury to the knee. A "Workers' Compensation Claim Form" prepared show Petitioner indicated that his "foot slipped off moving chain allowing knee to twist." (RX 4, p.2)

Petitioner testified as to his current symptoms in his right knee. He has pain with walking, especially when he walks backwards while pulling milk crates. He occasionally wears a knee brace. He takes over-the-counter "Aleve" for pain. His right knee now bothers him at work, but he works through the pain. On cross-examination, Petitioner denied that he was non-compliant with his physical therapy, although he admitted that he probably re-scheduled a few times. He admitted to being in a car accident in August 2015 but denied injuring his right knee. Petitioner stated he injured his right middle shin. Records submitted show Petitioner was seen in the emergency room at Unity Point where it was recorded Petitioner "...hit the back of his head on the seat and also suspected he hit his right anterior shin because he now has swelling and pain to this area."(RX 5, p.29)

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

Petitioner's testimony shows that on November 30, 2013 he was walking backwards in a cooler pulling a stack of milk when he slipped and fell forwards, striking his chest and his right knee. Petitioner gave immediate notice and a written "Incident Report" was completed. Petitioner wrote, "stacking gallons fell forward landing on chest and knee was injured." Petitioner sought immediate medical attention, going to the Methodist Medical Center emergency room that night. The "Triage" portion of the records show, "Patient states that while at work he fell and now has pain to right knee. Patient states that he works at Prairie Farms." The "Clinician History of Present Illness" portion of the record show "...The patient states that this problem is job related...Injured in a fall...Lost balance and fell...Patient complains of pain over the right knee. Local soft tissue swelling over the right knee...Suffered a "twisting" knee injury." Petitioner began treating at IWIRC on January 10, 2014 where he provided a history that on November 30, 2013 at 1:00 a.m. he was pulling a stack of milk out of the cooler, lost his footing, and fell forward striking his right knee on a crate and the floor. IWIRC diagnosed a right knee contusion/strain. Due to continual complaints, a MRI of the right knee to rule out ligamentous pathology was ordered. The MRI when completed demonstrated a horizontal tear of the body and posterior horn of the medial meniscus; diffuse chondromalacia, and a small joint effusion. After an assessment of right knee medial meniscal tear, Petitioner was referred for an orthopedic consult at Midwest Orthopedic.

Petitioner initially saw Dr. Mike Gibbons on April 10, 2014. He gave a history of slipping and falling on a wet floor on November 30, 2013 while stacking boxes. Petitioner thought he twisted and landed on his right knee, but since the accident happened so fast, he was not 100% sure. Dr. Gibbons diagnosed right knee medial meniscus tear and mild medial compartment chondrosis. The doctor recommended right knee arthroscopy which was carried out on May 23, 2014.

The only medical opinion specifically addressing the issue is that of Dr. Russo, who found a causal connection between the torn meniscus and chondral injury and the November 30, 2013 accident. Dr. Russo opined that horizontal meniscus tears are more commonly associated with trauma. Dr. Russo testified that he reviewed all of the treatment records from Methodist Hospital, IWIRC, and Midwest Orthopedic. This opinion is consistent with the treatment records and Petitioner's testimony.

Based on the above, the Arbitrator finds that the preponderance of evidence dictates that a causal relationship exists between Petitioner's right knee condition of ill-being and accident sustained on November 30, 2013.

In Support of the Arbitrator's decision regarding (L) What is the nature and extent of the injury, the Arbitrator finds as follows:

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, 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 the injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

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

i. Petitioner presented an AMA report which indicated a 2% impairment rating of the lower extremity and 1% of a person indicating residual loss of function with normal range of motion. The AMA evaluator noted his physical examination grade modifier was a +1 based on findings of significant tenderness and swelling at the knee joint. The Arbitrator accords weight to this factor

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

ii. Petitioner returned and continues to perform his full duty work, albeit with discomfort. The Arbitrator accords some weight to this factor.

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

iii. Petitioner was 48 years old at the time of injury. Because of the length of time Petitioner will live with his permanent disabilities, the Arbitrator gives some weight to this factor

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

iv. There is no evidence that Petitioner's earning capacity has been affected. As such, the Arbitrator accords no weight to this factor.

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

v. Petitioner underwent surgical repair of his torn medial meniscus in the form 1.) right knee arthroscopy with partial medial meniscectomy; and 2.) chrondroplasty medial femoral condyle. Records submitted show Petitioner was last seen by physician on February 23, 2015, that being the IME physician, Dr. Russo. At that time, Dr. Russo noted obvious swelling of the right knee (2 cm circumference greater than the uninjured left knee), tenderness in the medial compartment, limited range of motion with flexion in the right knee, and an altered gait with reduction of weight bearing on the right foot. Dr. Russo diagnosed Petitioner with a right medial meniscus tear status post arthroscopic partial meniscectomy and a small chondral lesion of the right medial femoral condyle, status post chondroplasty. Petitioner testified to residual complaints of pain, especially when he walks backwards while pulling milk crates. He occasionally wears a knee brace. He takes over-the-counter "Aleve" for pain. His right knee now bothers him at work, but he works through the pain. The Arbitrator accords weight to this factor.

The Arbitrator had the opportunity to review the medical records and observe Petitioner's testimony. The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 22-1/2% loss of use of the right leg under 8(e) of the Act.

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

Petitioner's Exhibit 7 is a compilation of outstanding medical bills and a health insurance lien. The first balance is from Midwest Orthopedic Center, Dr. Gibbons and physical therapy; the next two bills are for the emergency room physicians on November 30, 2013 and March 3, 2014; the next bill is from DJO Global for a post-operative knee mobilizer/icer prescribed by Dr. Gibbons on May 15, 2014; the next bill is from Associated Anesthesiology for the surgery on May 30, 2014; the next bill is from OSF for pre-operative services on April 25, 2014; the next OSF bill is for a Doppler study necessary for surgical clearance, performed on May 21, 2014; the final OSF bill is the facility charge for the surgery on May 23, 2014; the next bill is from Central Illinois Radiology for the knee x-rays taken on November 30, 2013; and the next bill is for pre-operative labs done on May 15, 2014.

Having found the issue of causal connection in favor of Petitioner, the Arbitrator awards the bills enumerated above. Said bills are to be paid consistent with the medical fee schedule.

The Arbitrator notes that also included in Petitioner's Exhibit 7 is a BlueCross BlueShield lien in the amount of $7,182.63. This is Petitioner's health insurance which he has through his employment with Respondent. Respondent is entitled to an 8(j) credit for this lien. The lien includes payments to Methodist Medical Center, the emergency room physicians, Midwest Orthopedic Center, Central Illinois Pathology, Heartcare Midwest, OSF, Associated Anesthesiology, and OSF Medical Group. Respondent shall keep Petitioner safe and harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to extent of such credit.

The total medical bills and lien award is $8,591.74.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WINSTON GILLETT,

Petitioner,

16IWCC0410

vs.

NO: 12 WC 19630

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

Respondent appealed the June 26, 2015 §19(b) Decision of Arbitrator Carlson finding that Petitioner, a 44 year-old plumber, sustained accidental injuries arising out of and in the course of his employment on May 14, 2012, that Petitioner provided timely notice of the accident, that Petitioner's current condition of ill-being is causally related to the accident, that Petitioner was temporarily totally disabled for a period of 74 weeks, from May 15, 2012 through October 14, 2013, at the rate of $708. 53 per week under §8(b), that Respondent is entitled to a credit of $5,000.00 toward temporary total disability benefits owed based upon other benefits

paid, and that Respondent shall pay $2,434.57 to Edward Hospital and $10,778.70 to DuPage Medical Group pursuant to §8(a) and §8.2 of the Act.

Based upon a review of the record as a whole, the Commission modifies the Arbitrator's Decision to find that Petitioner was at maximum medical improvement with respect to his May 14, 2012 work-related injury on January 13, 2013, and that his condition of ill-being was no longer causally connected to his work-related injury as of that date. In so finding, the Commission relies upon the more persuasive opinions of Dr. Thomas Gleason, Respondent's §Section 12 examiner, and of the opinions of Dr. David Trotter, the physician who conducted a §8.7 Utilization Review pursuant to Respondent's request.

Dr. Thomas Gleason testified that he initially conducted a §12 examination of Petitioner on August 21, 2012, pursuant to Respondent's request, and thereafter issued supplemental reports on September 24, 2012, December 23, 2012, and on January 13, 2013. (RX1, T6-7). He testified that Petitioner provided a history of a May 14, 2012 work injury when pulling a rodding machine up some stairs and sustained an injury to his low back, right front pelvic area and outer aspect of his right elbow. Dr. Gleason testified that he found no positive objective findings on his examination of Petitioner relative to his lumbar spine, that he reviewed the MRI scans, including films from June 15, 2010 and August 21, 2012, x-rays he obtained during his examination of Petitioner, and MRI scans with and without contrast from June 8, 2012 and June 13, 2012.

He opined that the June 8, 2012 and June 13, 2012 MRI scans showed moderate degenerative disc disease at L4-5 with disk space narrowing and anterior osteoarthritic spur formation, and a right interforaminal disk protrusion at L4-5 w/ some foraminal narrowing, but no impingement of any significance that would either substantiate or explain some of the complaints Petitioner had during his August 12, 2012 evaluation with regard to pain in his legs. As of August 12, 2012 evaluation, he opined that Petitioner did not require any additional medical treatment; only a home exercise program and some weight loss. Dr. Gleason testified he found inconsistencies and contradictions on exam suggesting at the least exaggeration or magnification. (T18-22). Dr. Gleason further testified that while Petitioner's treatment to date was reasonable, it was largely unnecessary and excessive and unrelated to any May 14, 2012 work-related accident.

He testified that based upon the records reviewed, exam of Petitioner, description of injury, and absence of acute findings or changes on the imaging studies, the alleged injury might have been a competent cause of some right lower back pain, consistent with a soft tissue type strain and/or temporary aggravation of preexisting condition, but that he would expect it to resolve within 2 to 3 months. Dr. Gleason also testified that the medical records reviewed indicated that it had been less than a year since Petitioner had had chronic similar problems that were not improving and for which lumbar injections were recommended but not approved, thus raising question in his mind as to whether Petitioner continued to have similar type complaints from his prior condition of ill-being. (T22-25).

Dr. Gleason testified he subsequently reviewed additional medical records from Dr. Mataragas, and then he issued a supplemental report on September 24, 2012, addressing the lumbar fusion at L4-5 proposed by Dr. Mataragas. Dr. Gleason opined that Petitioner was not in need of any further medical care or treatment, and specifically not the fusion proposed by Dr. Mataragas. His opinion was based upon the physical examination of the Petitioner and his record review. Dr. Gleason testified that at the time of Petitioner's August 21, 2012 examination Petitioner complained of intermittent pain over the low back, to the posterior aspect of the right thigh, to the knee and over the R front aspect of the pelvis, and that this examination demonstrated no positive objective findings on exam relative to the spine. Dr. Gleason testified Petitioner's examination findings were not consistent and the exam did not suggest an irritation of the L4-5 nerve root, and that a fusion was not indicated for right low back pain in situation like this. He opined Petitioner should pursue a home exercise program, weight loss, and that he was capable of returning to work full duty with respect to his spine as of the prior August 21, 2012 examination. (T25-28).

Dr. Gleason further testified he reviewed Petitioner's prior MRI films of June 2010, and compared them to all of Petitioner's other diagnostic studies including the MRIs of June 2012, and that all of the other studies, and the findings showed moderate degenerative disc disease at L4-5 with disk space narrowing and anterior osteoarthritic spur formation. He testified there existed a right interforaminal disk bulge at L3-4 as well as a right interforaminal disk protrusion at L4-5 with foraminal narrowing, and that the June 2010 scan was otherwise unremarkable and the finding were unchanged from June 26, 2010 to June 8, 2012, and June 13, 2012. He further testified that he looked at specific cuts on the MRI studied, the T1 axials, image 35 on the June 2012 study as compared to June 2010 study, that those findings were unchanged, and that the two studies from 2010 and 2012 were of significantly similar quality. (T28-31).

On January 13, 2013, Dr. Gleason issued a supplemental report, DEP EX5, in RX1. Dr. Gleason opined that the MRI scans of the lumbar spine from June 8, 2012, June 13, 2012, and June 26, 2010 were all of adequate and comparable quality, with each film demonstrating a moderate degenerative disc disease at L4-L5 with disc space narrowing and anterior osteoarthritic spur formation, with a right interforaminal disc bulge at L3-L4 as well as right interforaminal disc protrusion at L4-l5 with foraminal narrowing. He opined the findings on the MRI scans were unchanged to a reasonable degree of medical certainty from June 26, 2010 to June 8, 2012 and June 13, 2012, and that there was no obvious increase in the objective extent of any herniation.

Pursuant to Respondent's request, Dr. David Trotter conducted a §8.7 Utilization Review on February 12, 2013, with respect to L4-5 right sided minimally invasive transforaminal interbody fusion proposed by Dr. Mataragas. (RX2). Dr. Trotter testified he issued an opinion on whether the fusion procedure being considered was related to the date of injury, and whether the procedure itself was reasonable and medically necessary. He testified he had a significant question about its relatedness and felt that it was likely unrelated to the date of injury. His

opinion was premised upon the fact that Petitioner discussed a pre-existent back injury and/or condition, and an MRI report of 2010, prior to the date of injury, that was noted to really not have changed since the date of injury and thereafter. Dr. Trotter testified that from a medical perspective alone, without considering causation, the indications for the surgery were not there. (RX2, T5-10). Dr. Totter testified there were four things he found wrong with certification: no recent examination; no evidence of any segmental movement on x-rays; no psychosocial screening; and, differing opinions in the records from different providers/evaluators with regard to whether the procedure was reasonably necessary. He also testified that at the time of Petitioner's August 2, 2012 office visit with Dr. Mataragas, the doctor really did not delineate any exam or positive findings at all, and that the last physical exam of Petitioner was on May 21, 2012. He testified that the proposed treatment, surgical, in particular, was not reasonable or medically necessary. (RX2, T10-17).

Accordingly, the Commission finds that Petitioner failed to prove his current condition of ill-being is causally connected to his May 14, 2012 work-related injury, and that Petitioner's claim for temporary total disability benefits and medical benefits subsequent to January 13, 2013 is hereby denied.

Based upon the opinions of Dr. Gleason and the results of the Utilization Review, the Commission concludes Petitioner is entitled to an award of temporary total disability benefits for a period 34-6/7 weeks, commencing May 15, 2012 through January 13, 2013, at the rate of $708.53 per week, under §8(b) of the Act. The Commission further concludes that Petitioner is entitled to an award of reasonable, necessary and related medical expenses through January 13, 2013, under §8(a) and subject to under §8.2 of the Act. The Commission vacates the Arbitrator's award of $10,778. 70 for medical expenses under §8(a) of the Act, itemized in Joint EX4, for medical treatment incurred after January 13, 2013, and instead orders Respondent to pay to Petitioner the sum of $9,578.81 for medical expenses related to Petitioner's medical treatment at DuPage Medical Group, incurred from May 14, 2012 through January 13, 2013, itemized in PX2 and Joint EX7, under §8(a) of the Act, which has been calculated as the amount due pursuant to the Medical Fee Schedule under §8.2 of the Act. The Commission affirms the Arbitrator's award of $2,434.57 for medical expenses related to Petitioner's May 16, 2012 emergency room treatment at Edward Hospital, itemized in PX2 and Joint EX7, under §8(a) of the Act, which has been calculated as the amount due pursuant to the Medical Fee Schedule under §8.2 of the Act.

With regard to the $5,000.00 credit granted to Respondent, based upon the Commission's finding that Petitioner was at maximum medical improvement as of January13, 2013, the Arbitrator's award of a $5,000.00 credit to Respondent for Petitioner's occasional earnings in 2013 is hereby vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 26, 2015, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

16IWCC0410

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $708.53 per week for a period of 34-6/7 weeks, for the period of May 15, 2012 through January 13, 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 based upon the Commission's finding that petitioner was at maximum medical improvement as of January13, 2013, the Arbitrator's award of a $5,000.00 credit to Respondent for Petitioner's occasional earnings in 2013 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,434.57 for medical expenses related to Petitioner's May 16, 2012 emergency room treatment at Edward Hospital, itemized in PX2 and Joint EX7, under §8(a) of the Act, which has been calculated as the amount due pursuant to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of $10,778. 70 for medical expenses under §8(a) of the Act, itemized in Joint EX4, for medical treatment incurred after January 13, 2013, is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $9,578.81 for medical expenses related to Petitioner's medical treatment at DuPage Medical Group, incurred from May 14, 2012 through January 13, 2013, itemized in PX2 and Joint EX7, under §8(a) of the Act, which has been calculated as the amount due pursuant to the Medical Fee Schedule under §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 Petitioner's request for prospective medical care under §8(a) of the Act is denied.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,800.00. 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: JUN 17 2016
KWL/kmt
O-05/09/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0410

GILLETT, WINSTON Case# **12WC019630**

Employee/Petitioner

PERFECT HOME SERVICES

Employer/Respondent

On 6/26/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0659 BRILL & FISHEL PC
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CHICAGO, IL 60601

0445 RODDY LAW LTD
ROBERT J DOHERTY
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0410

Winston Gillet
Employee/Petitioner

v.

Perfect Home Services
Employer/Respondent

Case # 12 WC 019630

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 2, 2012** and **April 1, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0410

FINDINGS

On the date of accident, **May 14, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**10,442.80**; the average weekly wage was $**1,062.80**.

On the date of accident, Petitioner was **44** 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 $ **5,000.00** for other benefits, for a total credit of $**5,000.00**.

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

ORDER

Respondent shall pay the Petitioner temporarily total disability benefits of $ 708.53 / week for 74 weeks commencing on May 15, 2012 through October 14, 2013 as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule of $ 2,434.57 to Edwards Hospital and $ 10,778.70 to DuPage Medical Group as provided in Sections 8(a)and 8.2 of the Act.

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

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

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

Signature of Arbitrator

June 26, 2015
Date

ICArbDec19(b)

JUN 26 2015

FINDINGS OF FACTS

There were two hearings on this matter: July 2, 2012 and April 1, 2015.

HEARING I July 2, 2012

The Petitioner, Winston Gillett, testified that he was hired by Perfect Home Services (Respondent) as a plumber/technician in March, 2012. On May 14, 2012, he was on call. At approximately 6:30-7:00 p.m., the dispatcher called him and sent him to a residence in Barrington. It was a single family home. The job required him to clear a main line stoppage. Petitioner arrived at the home around 10:30 p.m. Petitioner explained that the job "entailed me removing my 200-pound Rigid 7500 machine, take it down to the basement into a three foot crawl space, sitting on a bench and rodding out the main sewer line from that point." (Trial I-Tr. pg. 18) Petitioner explained that the heavy machine had wheels but he had to pull the machine up the stairs and get the machine back on the truck. Petitioner testified that as he was pulling the machine up the second step, he heard a crack and felt pain in his back, pelvis area and right elbow. He was able to get the machine up the stairs and rolled it up the ramp and into the truck. He then wrote a receipt for the customer and collected the check.

He testified that he got into his truck and called his direct supervisor, Tommy Ayers. He testified that he told Ayers that he had been injured and that the truck and telephone were "acting up." He testified that truck was not going more than 30 mph and the telephone was not sending his dispatch emails. Petitioner testified that when he told Tommy that he hurt his back, the response was, "Go home and get some rest."

The next day, May 15, 2012, Petitioner testified that he called Ayers in the morning to tell him that he was going to a company named, Heatmasters, to pick up a check which was a deposit for a job he had sold. Petitioner testified that he prepared two contracts for the job. Petitioner testified that both Blake Bernard and Tommy Ayers saw the contracts he had prepared. Petitioner explained that part of the job was to demolish bathrooms. The bathrooms required mold removal and Petitioner contracted with a company named Magic Mold Removal. The contact person for Magic Mold Removal was Shane Knight.

Petitioner testified that Shane Knight drove him to Headmasters the morning of May 15, and he picked up two checks totaling $6,000.00. He gave one check to Knight in the amount of $3,000.00. Knight then drove him home. Petitioner then drove the company's truck to Respondent's office. He testified that he handed the check to Tommy Ayers with the paperwork for the job. He also gave him the phone and the keys to the truck.

Petitioner testified that at that point, Ayers told him that "Well, I'm sorry, things are not working out, we have to part ways." Petitioner stated that he did as he was told and provided all his paperwork to Tom, the accountant. At that point, Petitioner asked Tommy Ayers to give him a ride home and Ayers drove him home. During the ride, Petitioner testified that Ayers told him, "I know I have a friend at Reliance Plumbing, you know, there's a bunch of Belizeans that work there; maybe you can go get a job there." Petitioner explained that he was born in Belize.

The next day, Wednesday, May 16th, Petitioner testified that he called Heatmasters and told them that he was terminated and would not be doing the job. He testified that the manager at Heatmasters' was upset and said, "I don't give a damn. I just want my job finished. I don't care who finishes it." Petitioner then called Shane Knight and asked him if he would agree to go to Heatmasters. Petitioner stated that he and Knight drove out to the job site and met with owner. Petitioner testified that he never returned to that job site after that day and never did any work for Heatmasters.

Petitioner also testified that he later called Justin Carroll, the owner of Perfect Home Services and spoke to him on the phone. Petitioner stated that Carroll told him to hold on and speak to his fiancée who told him to file a "45 or something." Petitioner stated that Carroll called him back and interviewed him about the accident. Petitioner stated that he answered all of Carroll's questions. Petitioner testified that Carroll told him, "Off the record, I want to tell you you're a smooth criminal." (Trial I-Tr. p. 46)

TESTIMONY OF TOMMY AYERS

July 2, 2012

Tommy Ayers was called as a witness by Respondent. Ayer was the plumbing and sewer manager. He was Petitioner's supervisor, but he was not an owner of the company. He testified that the company was not happy with the performance of Petitioner. Ayers testified that the week of May 1, 2012, he was preparing to go on vacation and the owner, Justin Carroll, told him via email to fire Petitioner. (Trial I-Tr.p.53) He testified that he did not feel comfortable doing so because he was a new manager. He did not fire Petitioner before his vacation. He returned from the vacation and his first day back was May 14, 2012. He met with Petitioner that day and they went to Heatmasters in Chicago. He explained that Heatmasters was a job that Petitioner had sold during his vacation. Ayers testified that he saw Petitioner in the afternoon of May 14th and they discussed the Heatmasters job. Ayers testified that he later spoke with Blake Bernard and Mike Dressler regarding Petitioner's termination. Ayers testified that he was concerned as to whether Petitioner would in fact bring the check to the office from Heatmasters. He testified that on the evening of May 14th he spoke to Petitioner to confirm that Petitioner would bring a check from Heatmasters in the amount of $3000.00 to the office the next day.

Ayers testified that he sent Petitioner to do a job that evening in Barrington. He confirmed with Petitioner that the job was to take care of "backed up" lines. Ayers testified that later that evening he received a call from Petitioner. Ayers said that Petitioner told him that the vehicle was running slow but denied that he was told about an injury on the job. The next day, Ayers confirmed that Petitioner did bring the Heatmasters check to the office. (Trial I-Tr. p. 64) He confirmed Petitioner's testimony that he brought his keys and telephone to the office the day after the accident as well. Ayers also testified that after he fired Petitioner, he told him to apply to Reliance Plumbing because he was "Belizean."

Ayers testified that he subsequently received a call from Heatmasters on May 16, 2012, and went to the job site. Ayers testified that Respondent completed the work at Heatmasters and was paid for the job.

April 1, 2015

At the second hearing, Ayers gave detailed testimony as to the details of the Heatmasters job. He stated that Respondent did in fact complete the job and received payment in the amount of $15,000.00. Ayer was asked again to relate the events of the night of the accident. He again testified that he sent Petitioner to a job in Barrington the night of the accident. Ayers did not remember the details of the evening of the accident. He did state that he would get calls from the servicemen after a job if there were "problems or something was wrong." (Trial II-Tr. pg. 105) This time Ayers did not recall if he got a call from Petitioner that evening. He did admit that he might have called because "some guys did call me absolutely." (Trial II-Tr. p. 106) Ayers did not recall the nature of the conversation.

MEDICAL TREATMENT

The medical records from DuPage Medical Group and Edward Hospital were admitted as Joint Exhibits 1-12.

Petitioner testified that he was in pain after the accident, but he first tried to relax and lay down. On May 16, 2012, he returned from the job site at Heatmasters, but his pain was such that he could not walk and was feeling pain down the right side of his leg.

He then went to the emergency room at Edward Hospital in Naperville, Illinois. The records show that Petitioner complained of sharp stabbing pain in his lumbar spine. (JE#5 pg. 5-6) The records indicate that the diagnosis was acute musculoskeletal back strain with lumbar radiculopathy and right elbow pain. (JE#5 pg. 7) He was taken off work. (JE#6)

On May 22, 2012, Petitioner returned to his doctors at DuPage Medical Group. He first saw Dr. Paul Manganelli. The office note indicates:

> Winston Gillet presented with right groin and low back pain with posterior thigh pain to lateral lower leg. The history indicated that "since the last visit patient was last seen on 8/11, at which time, he had been complaining of LBP with right LE pain. WC denied any injections, and as such, did not undergo any injections in 2011 (had facet blocks in 2010). Without specific treatment, he states that his pain did improve, and returned to working out at the gym." (JE#1 pg. 127)

The records from DuPage Medical Group document an accident of May 14, 2012, stating he was pulling a heavy tool, and felt a pop in his low back. He had onset of pain in right groin and elbow. By the next day, he developed right lateral lower leg pain, and was seen in ER on May 16, 2012. (JE#1 pg. 127) The doctor prescribed an MRI so they could compare the previous MRI and the new one. (JE#1 pg. 128) Dr. Manganelli wrote a workers' compensation status report that he is unable to perform any work at this time. (JE#2)

On June 1, 2012, Petitioner returned to Edward Hospital with low back pain radiating down his right leg. (JE#5 pg. 18) His diagnosis was acute exacerbation of chronic back pain and probable disc disease. (JE#5 pg. 19)

On June 8, 2012, Petitioner underwent the new MRI scan. The impression was multilevel degenerative disc disease. "Right foraminal changes at L4-5 require follow-up post-contrast imaging, as underlying nerve sheath tumor or superimposed disc herniation cannot be excluded." (JE# 8)

On June 13, 2012, Petitioner saw Dr. Mataragas after being referred by Dr. Manganelli. The clinical examination showed that the patient was in obvious discomfort and constantly changing position and sitting leaning to the left side. He had a significantly positive straight leg raise on the right side reproducing his pain. The doctor referred him for a MRI scan with contrast. (JE#1 pg. 121) Dr. Mataragas prepared a workers' compensation status report that he was unable to perform any work at this time. (JE#2)

On June 14, 2012, Petitioner underwent a lumbar transforaminal epidural steroid injection performed by Dr. Paul Manganelli. (JE#1 pg. 113). On July 6, 2012, he underwent his second injection. On July 13, 2012, he underwent his third injection.

On August 14, 2012, Petitioner returned to Dr. Mataragas who recommended a right sided minimally invasive transforaminal lumbar interbody fusion. (JE#1 pg. 90)

On October 11, 2012, Petitioner saw Dr. Abdel Fahmy. Dr. Fahmy's notes indicate that Petitioner was having pain issues. (JE#1 pg. 78) Dr. Fahmy provided counseling on the side effects of pain medications. Dr. Fahmy noted, "Patient has genuine pain and will continue pain management till surgery is approved..." (JE#1 pg. 80)

On August 28, 2013, a follow up MRI was performed and compared to the MRI from June 8, 2012.

On October 14, 2013, the office note details MRI results and notes that the patient complains of low back pain down the right leg. The plan was to refer him to chiropractic care. He remained with the current job restrictions. (JE#1 pg. 1-2)

On January 24, 2014, Petitioner was again seen by Dr. Fahmy. (JE#1 pg. 136)

TESTIMONY OF DR. NICHOLAS MATARAGAS

Dr. Mataragas testified via deposition on December 19, 2012. (PX#1) He first examined Petitioner in June, 2012. He took a history from the patient who indicated that he injured his low back after lifting a 200 pound machine at work. The clinical examination revealed that he had increased pain with flexion, extension of the lumbar spine and a positive straight leg raise which he explained indicates a compressed or pinched nerve. He stated that the clinical examination comported with the findings on the MRI. The diagnosis was herniated nucleus pulposus with lumbar radiculopathy of L4-5. He recommended a follow up MRI with gadolinium to rule out a nerve sheath tumor and he referred him for epidural steroid injections. The follow up MRI confirmed his diagnosis. The doctor testified that his patient underwent three injections and returned on August 9, 2012 for a follow-up. On August 14, 2012, Dr. Mataragas saw him and recommended surgery in the form of a minimally invasive transforaminal lumbar interbody fusion. (PX#1 pg 9) The doctor testified that he did not see the patient after that date. Dr. Mataragas ordered him off work.

In regards to causal connection, Dr. Mataragas explained that the patient would not be able to do heavy work with the condition he had. (PX#1 pg.14)

> He further testified, "This is most likely a fairly acute event. I mean, he has chronic degeneration of the 4-5 discs, but I'm looking at the MRI right now, and by all indications this disc herniation is fairly acute looking. So I would say it's within the last six months." The doctor further explained that "the fact that the radiologist was having a hard time determining whether this was a disc herniation or a nerve sheath tumor tells me the appearance of it is more likely to be acute." (PX#1 pg. 14)

The doctor concluded that the mechanism of injury would match the history of the accident. (PX#1.pg 14)

On cross examination, he was asked if the recommendations were based on the assumption that the incident reported that occurred on May 14, 2012 actually occurred as stated. The doctor stated that his opinion was "based on his clinical condition regardless of the history..." (PX#1 pg. 15)

Further, on cross examination, the doctor explained, "that even if the patient had a herniation in 2010, and some leg pain symptoms, radicular symptoms, prior to this newest MRI, but there's no way of quantifying really the severity of this problem. Where before may it was something he could live with, and then another trauma on top of what he had before could have exacerbated his condition." (PX#1 pg. 25)

Finally, the doctor explained that there is a more acute component to the disc herniation as well.

> "I feel pretty confident that he has a superimposed extra disc herniation on top of what he had before." He further explained that by looking at the cuts on the MRI, he could see on Image #35 that "there's a complete occlusion of that L4-5 neuroforamen." "Then you compare that to his previous MRI. And I'm looking at the same area. And I just don't get the same impression that there's as much fullness in the foramen." (PX#1 pg. 27-28)

The doctor was asked whether the fact that radicular symptoms were not present 10 days after the accident would not change his opinion. He responded, that "a lot of time the radicular complaints don't start for a little while following the trauma." (PX#1 pg. 33)

Finally, the doctor was asked if he has dealt with issues of secondary gain. The doctor responded that he had but that this case was not one of those issues

TESTIMONY OF DR. THOMAS GLEASON

Dr. Gleason testified at his deposition on January 15, 2013. (RX#1) He testified that he found no positive objective findings on his physical examination relative to his spine. (RX#1 pg. 18) He reviewed the MRI scans and found moderate degenerative disk disease at L4-5 with disk space narrowing and anterior osteoarthritic spur formation. (RX#1 pg. 19) He noted a right interforaminal disk protrusion at L4-5 with some foraminal narrowing. (RX#1 pg. 19) He found no impingement that would explain the pain in his legs. (RX#1 pg. 20)

However, Dr. Gleason stated that the event of carrying equipment up the stairs could be consistent with complaints of right lower back pain. (RX#1 pg. 24) He agreed with the statement that the individual presents with history, complaints, examination and review of records consistent with the diagnoses noted above. (RX#1 pg. 33) Dr. Gleason disagreed with Dr. Mataragas' recommendation for surgery but he acknowledged that he only saw the patient one time. (RX#1 pg. 35)

Subsequently, Dr. Gleason authored a follow-up report on October 26, 2014. (RX#3) In this report he notes that he reviewed the MRI scans of the lumbar spine from June 26, 2010, June 8, 2012, and June 13, 2012. Dr. Gleason again noted that the scans were of adequate and comparable quality. However, he then viewed the MRI scan of August 28, 2013 and stated that the scan:

> "Does suggest a slight increase in the size of both the right interforaminal disc bulge at L3-4 as well as the right interforaminal disc protrusion at L4-5 with associated foraminal narrowing. As compared with the other prior scans there is a disc protrusion at L4-5 with foraminal narrowing." (RX#3)

TESTIMONY OF DR. DAVID H. TROTTER

Dr. Trotter testified at his deposition on November 13, 2014. (RX#2) The doctor was questioned regarding his URAC report dated February 12, 2013, which was requested by Respondent. (JE#9) The utilization review was prepared at the request of GENEX. The doctor testified that he was asked to review whether Dr. Mataragas' recommendation for a minimally invasive transforaminal interbody fusion was medically reasonable or necessary. The doctor

testified that he did a twofold review. First, as to whether the proposed procedure was related to the date of injury. To that question, he responded that it was not related because there was a pre-existent back injury and an MRI report previously documented that showed no change since the date of injury. (RX#2 Pg. 10) Second, he rendered an opinion as to whether the proposed procedure was reasonable and necessary. Dr. Trotter listed the records he reviewed to prepare the report and consulted the ODG guidelines. He stated that there were three reasons why he did not certify the procedure. (RX#2 pg. 12-14)

1. No recent comprehensive examination
2. Segmental instability
3. Psychosocial screen evaluation.

He then recalled that there was one more reason, conflicting medical opinions.

On cross examination, the doctor admitted that URAC guidelines do not include or require findings on medical causation. (RX#2 pg. 18) The doctor also admitted that he had not performed fusion surgeries. He stated that he had assisted in fusion surgeries but could not recall when the last time he did so. (RX#2 pg. 19) Dr. Trotter also stated that he only reviewed one office note from Dr. Mataragas dated August 21, 2012. (RX#2 pg. 21)

In addition, Dr. Trotter testified that a recent comprehensive history and physical was absent, but the materials he received from his source were adequate to form an opinion. He had initially stated that the lack of that exam was the most significant factor. He later revised his testimony and said it was only one of the factors. (RX#2 pg. 24-25) He acknowledged that there may have been additional records, but the doctor explained that he was provided the materials to render an opinion and was only using those materials. (RX#2 pg. 28)

Dr. Trotter testified that he did not sign the report. The report was signed by Ann Smith. (RX#2 pg. 29) Dr. Trotter testified that he did not know who Ann Smith was. He also testified that he did not draft the report; the report was drafted by GENEX. (RX#2 pg. 29-30) He was asked, Q. "So, word for word, you drafted this language?" A. "No. Again, basically, certain extraneous

bells and whistles were added by the GENEX people to fit their template, but the guts of it are from my report—reflect my report." (RX#2 pg. 30)

PRIOR WORKERS' COMPENSATION ACCIDENT

Petitioner testified that he had been previously injured in a work related accident in January, 2010. The medical records from DuPage Medical Group document that Petitioner sustained the following injuries: (JE#10; JE#11 pg. 33)

1. Comminuted and displaced open tibial shaft fracture/open reduction internal fixation.
2. Calcaneal fracture
3. Degloving injury of the lower leg/hind foot.
4. Osteomyelitis of the lower leg
5. Fracture/traumatic rupture of the right superior pubic ramus
6. Herniated disc

On December 16, 2010, the records show the first injection therapy for his bilateral L4-5 and L5-S1 back pain. (JE#11 pg. 24) The medical records confirm that the last time Petitioner was treated for back pain from his 2010 injury, was on August 26, 2011. (JE#3)

Respondent provided a copy of the settlement contracts from that injury. (RX#9)

No lumber fusion surgery was ever prescribed for the 2010 injury.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to (C), did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator concludes as follows:

The Arbitrator finds Petitioner credible wherein he testified that he injured his back while lifting a heavy machine. The details were specific and coincide with the nature of the job he was sent to do. His testimony is consistent with the history documented in the emergency room records at

Edward Hospital and at DuPage Medical Group. The history taken in the emergency room was within 48 hours of the accident.

On a separate note, the Arbitrator feels compelled to comment on the credibility of both Petitioner and Respondent. The Arbitrator finds it suspect that even though Respondent allegedly was preparing to terminate Petitioner's employment; they chose to send him out on a service call on May 14, 2012. Ayers first testified that he was uncomfortable firing him before vacation. Upon his return, he explained that he did not fire him on May 14th, allegedly because he was waiting for Petitioner to deliver the check from Heatmasters. After reviewing the testimony about the Heatmasters job, it appears that the issue was raised by Respondent solely to impeach the credibility of Petitioner. Respondent conducted an extensive cross examination about the details of that job. It appears that Respondent was not pleased with Petitioner's choice of Shane Knight to do the mold removal. However, there is no testimony in the records that he was removed from the project after Petitioner was fired. Respondent's witness, Tommy Ayers testified at length about the Heatmasters job and the contracts or invoices prepared by Petitioner. The Arbitrator can only conclude that there was a job or contract that was obtained by Petitioner for the benefit of his employer. Ayers testified that they were anxious to get the check from Heatmasters. Ayers testified that they completed the job after Petitioner left their employment. Why didn't Ayers go to Heatmasters to pick up the check if Petitioner was going to be fired? The arbitrator finds that the issues surrounding the Heatmasters job are not relevant and have no bearing on the compensability of this accident.

Moreover, the whole employment termination scenario does not appear to be credible. If Petitioner was such a poor employee, why did the owner, Justin Carroll, not terminate him directly? At the first hearing, Petitioner testified that he spoke to Carroll regarding the injury, and that he answered all of Carroll's questions. Why did Respondent choose to bring Ayers to testify about the accident and not the owner of the company, Justin Carroll? There is no testimony that any warning or performance issues were ever discussed with Petitioner prior to May 15, 2012. The Arbitrator also finds that Ayers' recommendation that Petitioner seek work at a plumbing company where the employees were from Belize indicates that the entire basis for

the termination was suspect. Given the sequence of events, it appears that Respondent had no intention of terminating Petitioner until he gave notice of the accident.

On the other hand, Petitioner had a poor recollection of his release from care for his back pain. His memory regarding the details of his treatment for his back in 2010 and 2011 was not good. He had difficulty describing the difference between his previous back pain and his back pain after this accident.

The Arbitrator concludes that given the **objective** evidence in the record, Petitioner sustained an accident on May 14, 2012, which arose out of and in the course of his employment with Respondent.

In support of the Arbitrator's decision relating to (E), was timely notice of the accident given to Respondent, the Arbitrator concludes as follows:

Petitioner was credible wherein he testified that he called Tommy Ayers as soon as he left the job site that evening and told him that he injured his back. He also stated that he told Ayers that the truck and phone were not working well. At the first hearing, Ayers testified that Petitioner did call that evening but he did not mention that he hurt his back. At the second hearing, he testified that he did not remember if he even got a telephone call. The Arbitrator finds that Ayers' testimony was not reliable and not credible. Moreover, Petitioner testified at the first hearing that he spoke to the owner Justin Carroll and told him about the accident. He stated that Carroll questioned him regarding the details of the accident which he readily provided. As noted above, Respondent did not rebut that testimony. Finally, it is apparent that there was statutory notice of the accident, as the Application for Adjustment of Claim was filed on June 6, 2012, well within 45 days of the accident of May 14, 2012.

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

The Arbitrator acknowledges that this determination is complex. Fortunately, there is an abundance of medical records available for review that pre-date the accident and those subsequent to the accident. The vast majority of the records are from one source, DuPage Medical group. A careful examination of those records revealed that Petitioner sustained a massive injury in 2010. The records show that Petitioner did complain of back pain subsequent to the 2010 accident and he did receive medication and therapy for his back pain. However, the records also show that there is a significant gap in medical treatment for his back pain from August, 2011 until May, 2012. Respondent cannot rebut the **objective** medical evidence. In addition, there is clear and convincing testimony from the treating physician Dr. Mataragas, that the post-accident MRI scans were different from the pre- accident MRI scan. He explained that difference in detail and supports his explanation with a description of specific cuts in the MRI scan, which he personally reviewed for the benefit of Respondent during the deposition. Dr. Mataragas explained that the scan shows a superimposed herniation and that the herniation was acute. He also stated that the patient could not have performed the heavy work he was doing given the evidence in the post-accident scans.

Moreover, the Arbitrator notes that even Dr. Gleason conceded in his October, 2014, report that the most recent scan shows a change in the L4-5 disc. The Arbitrator has reviewed the medical records and the testimony adduced at trial. Dr. Mataragas has provided a comprehensive and detailed opinion regarding the causation of Petitioner's back injury. The Arbitrator finds that the testimony of Dr. Mataragas was more credible than that of Dr. Gleason, especially since Dr. Gleason acknowledged the change in the disc that was evident in the most recent scan he reviewed.

On a separate note, the Arbitrator reviewed the UR report submitted by Respondent as RX#2. The Arbitrator notes that Dr. Trotter only reviewed one office note from Dr. Mataragas. Dr. Trotter contradicted himself regarding the importance of a recent clinical examination. He first stated that the exam was the most important factor in his determination of whether the recommended surgery met the ODG guidelines. He later stated that it was only one factor. Dr. Trotter could not recall when he last assisted in any spinal surgery. He was evasive when asked how many years had passed since his last assist. Dr. Trotter offered an opinion on casual

connection which is inappropriate and simply not the subject of a UR review. It showed that his opinion was biased. Most importantly, Dr. Trotter did not draft the report that was the subject of the deposition. It was prepared and signed by an employee at GENEX. The Arbitrator finds that Dr. Trotter was not credible and his UR report carries no weight.

It is well settled that a causal connection can be also be established solely by providing evidence of a chain of events analysis. Here, there is clear evidence of a break in medical treatment for his back, the ability to do a heavy job for a number of months, and the onset of severe pain which is linked to a specific event. Respondent offered no rebuttal evidence in that regard.

Based on the above, the Arbitrator finds that there is a casual connection between the accident of May 12, 2012 and his current condition of ill-being.

In support of the Arbitrator's decision relating to (J), whether the medical services provided to Petitioner were reasonable and necessary, the Arbitrator concludes as follows:

The Arbitrator finds that Petitioner underwent medical treatment that was reasonable and necessary and causally related to his accident. Petitioner has calculated the medical bills due and owing pursuant to the fee schedule. Respondent is liable for the sum of $13,222.27; $2,434.57 to Edwards Hospital, and $10,778.70 to DuPage Medical Group. (PX #2)

In support of the Arbitrator's decision relating to (L), what amount of compensation is due for temporary total disability; the Arbitrator concludes as follows:

The medical records support a finding that Petitioner was unable to do unrestricted work while he was waiting for medical treatment. Respondent has refused to pay a single day of TTD or any medical benefits. The Arbitrator finds that there is a lack of supporting medical evidence for the entire period of TTD alleged. Accordingly, the Arbitrator again must rely on the **objective** medical evidence that was submitted at trial. The last office note from DuPage Medical that restricts him from any work is dated October 14, 2013. Accordingly, the Arbitrator finds that Petitioner was temporarily and totally disabled from May 15, 2012 through October 14, 2013, a

period of 74 weeks at a TTD rate of 708.53. Petitioner testified credibly that he was able to obtain occasional employment during the years of 2013-2014. Petitioner testified that he estimated earnings of $5000.00 in 2013. Respondent shall be given a credit of $5,000.00 toward the TTD owed.

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Winston Gillet v. Perfect Home Services
Fee Schedule

Edwards Hospital
DOS: 5/16/2012

Code	Charges	Fee Schedule	
72110	$789.00	$327.87	
73080	$446.00	$162.62	
96374	$307.00	$163.32	POC 53.2
96375	$265.00	$140.98	POC 53.2
96376	$287.00	$152.68	POC 53.2
9928425	$1,591.00	$1,193	
J1170	$15.00	$7.45	
J2405	$5.25	$11.71	
99284	$449.00	$274.94	
	$4,154.25	$2,434.57	

DuPage Medical Group
DOS: 6/13/2012 - 10/11/2013

Code	Charges	Fee Schedule	
99213	$152.00	$64.92	
99213	$152.00	$64.92	
99213	$152.00	$64.92	
99213	$152.00	$64.92	
72149	$1,962.00	$1,377.53	
A9579	$152.00	$80.86	POC 53.2
72148	$1,618.00	$1,526.83	
99213	$152.00	$64.92	
99214	$224.00	$100.15	
80154	$58.00	$81.87	
80101	$390.00	$78.09	
99205	$434.00	$197.37	
80104	$75.00	$39.90	POC 53.2
64483	$900.00	$533.48	
64483	$900.00	$533.48	
80102	$68.00	$51.00	
83925	$215.00	$104.81	
80101	$390.00	$78.09	
99213	$152.00	$64.92	
80104	$75.00	$39.90	POC 53.2
99213	$152.00	$64.92	
99213	$152.00	$64.92	
99213	$152.00	$64.92	
99213	$152.00	$64.92	
99211	$43.00	$33.63	
99214	$229.00	$100.15	
99211	$43.00	$33.63	
99214	$229.00	$100.15	
99213	$157.00	$64.92	
80101	$390.00	$78.09	
99213	$157.00	$64.92	
99213	$157.00	$64.92	

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80104	$75.00	$39.90
99213	$157.00	$64.92
80104	$75.00	$39.90
99214	$229.00	$100.15
80104	$75.00	$39.90
99214	$229.00	$100.15
99213	$157.00	$64.92
80104	$75.00	$39.90
80104	$75.00	$39.90
64483	$4,000.00	$1,412.03
64483	$4,000.00	$1,412.03
64483	$4,000.00	$1,412.03
	$23,533.00	$10,778.70

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL REDER,

Petitioner,

vs.

NO: 11 WC 15828

16IWCC0411

SYSCO CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner was a Shuttle Driver for Respondent. He pulled two trailers which were joined together back and forth between their domicile and a warehouse in Des Plaines. Along with driving, his duties included hooking trailers together using a conversion dolly.

2. On March 10, 2009 it was stipulated that Petitioner was injured while unhooking the conversion dolly from the lead trailer. He was lifting up the conversion dolly when he felt a pop and sharp pain in his left knee. He also experienced pain in the center of his thigh and the outside of his left knee.

3. Petitioner initially received treatment at Alexian Brothers, but was referred to an orthopedist, Dr. Levin, who treated Petitioner from March 21, 2009 through November

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24, 2009. Petitioner was prescribed medications and given exercises to perform at home.

4. Petitioner returned to light duty on April 26, 2009.

5. A May 15, 2009 left knee MRI revealed severe osteoarthritis with synovitis and chondromalacia patellae, a Grade 2 medial collateral sprain and a degenerative complex tear of the posterior horn body.

6. On May 19, 2009 Petitioner was released to full duty work.

7. On August 11, 2009 Petitioner complained of increasing soreness over the left knee laterally. Was still released to full duty work.

8. On November 24, 2009 Petitioner was found to have reached Maximum Medical Improvement (MMI).

The Commission modifies the Arbitrator's ruling on nature and extent. The Commission views the evidence slightly different, and awards a 2% loss of use of Petitioner's left leg, based on his left thigh treatment and the May 2009 left knee MRI results.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $647.05 per week for a period of 4.3 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 2% loss of use of Petitioner's left leg.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,700.00. 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: JUN 17 2016
O: 4/21/16
DLG/wde
45

David L. Gore

Mario Basurto

Joshua Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REDER, MICHAEL
Employee/Petitioner

Case# **11WC015828**

11WC015829

SYSCO CHICAGO
Employer/Respondent

16IWCC0411

On 8/3/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
DAVID Z FEUER
I N LASALLE ST SUITE 2600
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JOSEPH A ZWICK
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Reder
Employee/Petitioner

v.

Sysco Chicago
Employer/Respondent

Case # **11** WC **15828**

Consolidated cases: **11 WC 15829**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **October 15, 2014 and November 3, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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 **March 10, 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 $**53,102.40**; the average weekly wage was $**1,021.20**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**4,571.09** 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

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $680.80 per week for 6-5/7 commencing March 11, 2009 through April 26, 2009, as provided in Section 8(b) of the Act.

Having determined that Petitioner suffered no permanent injury as a result of the alleged accident, no additional benefits are awarded in this claim.

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

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

Signature of Arbitrator

7/30/15
Date

AUG 3 - 2015

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

16IWCC0411

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL REDER Petitioner, vs. **SYSCO CHICAGO** Respondent.	)	No. **11 WC 15828** consolidated with 11 WC 15829

ADDENDUM TO THE DECISION OF ARBITRATOR

On October 15, 2014 and November 3, 2014, this matter proceeded to hearing pursuant to Section 19(b) of the Illinois Workers' Compensation Act (the "Act") before Arbitrator Jessica A. Hegarty in Chicago, Illinois. (Arb.1)

Petitioner filed two claims that were consolidated for trial. The Arbitrator has issued a separate decision for 11 WC 15829.

The only disputed issues with respect to the case at bar, 11 WC 15828, are causal connection and the nature and extent of the alleged injury. (Id.)

STATEMENT OF FACTS

Petitioner worked as a shuttle driver for Respondent, Sysco Chicago. His duties included hooking up trucks to trailers and pulling the trailers from a warehouse location to a domicile. On the date of accident Petitioner was 53-years-old. (Id.)

On March 10, 2009, Petitioner was involved in an undisputed accident while lifting a device called a "bogy" off a lead trailer. Petitioner testified that as he was lifting the bogy off a pintle hook, he felt a sharp pain in his left knee and what "felt like a pop." Petitioner testified that he also felt pain in the center of his thigh. Petitioner sought initial treatment at Alexian Brothers Hospital and then followed up with Dr. Mark Levin.

On March 31, 2009, Dr. Mark Levin of Barrington Orthopedics noted that Petitioner presented for an initial consult at which time he noted an accident history consistent with Petitioner's trial testimony. Petitioner reported feeling severe left lateral leg pain in conjunction with the accident. Petitioner reported that he had "a little injury" to the medial aspect of his proximal tibia when the hook hit him there. Dr. Levin noted that Petitioner's "lateral thigh pain appears to be related to hip pain and may be related to a labral tear versus degenerative hip arthritis". Dr. Levin recommended a left hip arthrogram MRI and released Petitioner to light duty, sitting only work.

On April 9, 2009 a left hip arthrogram MRI was performed and interpreted as unremarkable. On April 21, 2009, Petitioner presented to Dr. Levin who noted that the MRI showed no evidence of a labral tear or significant hip arthritis. Dr. Levin referred Petitioner to Dr. Brooke Belcher of Physical Medicine for evaluation.

On May 7, 2009, Petitioner presented to Dr. Belcher who noted Petitioner's report that he felt a severe "tearing" pain in the left lateral thigh in conjunction with the accident. The doctor noted Petitioner's "previous left hip and thigh pain has completely resolved, however his knee pain has remained." Petitioner reported feeling that his left leg is likely to "give out" at times and he had been using a cane for support. Dr. Belcher diagnosed a knee sprain/strain injury.

On May 15, 2009, Petitioner underwent an MRI of the left knee that was interpreted as showing:

1. Severe osteoarthritis with synovitis and chondralmalacia patellae and chondralmalacia articular cartilage trochlear groove;
2. Status post ACL repair with allograft that no longer demonstrated consistent with complete tear and mild sprain of the posterior cruciate ligament;
3. Chronic attenuation in the medial and lateral retinaculum with labral subluxation of the patella;
4. Grade II sprain medial collateral ligament and intermediate grade sprain of the collateral ligament;
5. Degenerative signal posterior horn of the medial meniscus without definite evidence of a tear;
6. Degenerative type complex tear involving posterior horn body and anterior horn lateral meniscus with lateral extrusion of the body of the lateral meniscus and;
7. Mild muscle strain of the medial head of the gastrocnemius muscle and contusion and hairline fracture lateral tibial plateau.

On May 19, 2009, Petitioner followed up with Dr. Levin who noted that "Mr. Reder has actually resolved all of his left leg pain" and could bend, stoop, squat, and climb. Dr. Levin recommended Petitioner's full duty return to work without restriction. With respect to the left knee MRI, Dr. Levin noted that the MRI shows chronic changes of the knee with osteoarthritic changes and that Petitioner "had an old ACL reconstruction that ruptured a long time ago". The doctor further noted that the MRI revealed "some degenerative changes with some bony contusion to the lateral tibial plateau."

Petitioner returned to Dr. Levin on August 11, 2009, at which time reporting increasing soreness over the left lateral knee when taking less Celebrex. Dr. Levin noted his continued recommendation for full duty work. The last note taken by Dr. Levin, dated November 24, 2009, notes that Petitioner had done quite well and was able to work full duty. Dr. Levin stated that Petitioner was at maximum medical improvement.

Petitioner testified that he returned to work on April 26, 2009 to light duty employment and to full duty employment thereafter.

Petitioner testified that he had previously seen a Dr. Fahey, who "rebuilt" his knee in 1990. Petitioner states that he was "working okay" from 1990 until 2009. Petitioner denied any treatment to his knee until the March 10, 2009, accident.

Petitioner's Exhibit 1a contains the operative report of Dr. Howard Freedberg, the surgeon who performed Petitioner's left knee replacement surgery on June 11, 2012. The indications for the surgery are noted as, "[t]his is a 56-year-old male who had prior surgery and was actually doing well until a workman's compensation accident, where the accident exacerbated his preexisting degenerative joint disease."

Respondent submitted as Exhibit Number 4, the evidence deposition of Dr. Raab completed on September 30, 2013. Also attached to the transcript was Dr. Raab's report from an evaluation dated October 28, 2011. Dr. Raab noted that the MRI in 2009 showed evidence of exposed bone and severe degenerative arthritis of the lateral compartment. (P 10). Moreover, Dr. Raab noted that there was no ACL reconstruction present on the MRI from 2009. In addressing the same, Dr. Raab testified, "He had severe arthritis. You couldn't even see a remnant of the reconstruction. This was chronic. It was long standing." (P 12). Dr. Raab further explained that the ACL reconstruction had failed prior to March of 2009. (P 13) Dr. Raab testified that Petitioner's diagnosis was severe degenerative arthritis of the left knee which was clearly documented at the time of the alleged injury in 2009. Dr. Raab opined that the ultimate treatment was not causally related to the alleged injury of March 10, 2009, nor was it causally related to the alleged injury of March 23, 2011. (P. 10). Petitioner's complaints as of the date of his IME evaluation (October 28, 2011) "were simply the natural progression of his severe degenerative arthritis in his knee and that was preexisting and present prior to his work-related injury of March 10, 2009." With regard to any potential aggravation, Dr. Raab noted, "Whatever injury, if there was one, that he sustained was temporary aggravation of his knee, at most. I believe that he had preexisting arthritis based on a review of the records and would have required this knee replacement with or without whatever work-related injury that he sustained."

CONCLUSIONS OF LAW
CASE NUMBER 11 WC 15828

In relation to causal connection, the Arbitrator finds as follows:

The Arbitrator notes that Respondent stipulated to accident in this claim. The same appears to be an un-witnessed event in which Petitioner alleges he was lifting a device called a "bogy" when he felt a sharp pain and a "pop" in his left knee. He further testified that he had pain in the center of his thigh. The initial medical records, however, indicate Petitioner feeling severe left lateral leg pain in conjunction with the accident and "a little injury to the medial aspect of his proximal tibia when the hook hit him there." Dr. Levin noted that Petitioner's "lateral thigh pain appears to be related to hip pain and may be related to a labral tear versus degenerative hip arthritis". Dr. Levin recommended a left hip arthrogram MRI, no treatment recommendations were made concerning the left knee. Dr. Levin's follow-up note of April 14, 2009, notes an impression of left hip/thigh pain. There is a reference to knee pain with no locking or giving out. At no point in the records is there any description of a "pop" in the knee. When Petitioner saw Dr. Belcher on May 7, 2009, she notes that Petitioner reported that he felt a severe "tearing" in the "left lateral thigh" at the time of the accident. Petitioner did note numbness throughout the left leg and Dr. Belcher noted that Petitioner reported the same had been present since a lumbar discectomy in 1993. When Petitioner saw Dr. Levin on May 19, 2009, he reported that all of his left leg pain had resolved and Dr. Levin released Petitioner for full duty employment. Dr. Levin's last note of November 24, 2009, indicates that Petitioner had done quite well and was working full duty.

There does not appear to be any dispute that Petitioner had a significant pre-existing condition in his left knee. Petitioner acknowledged his prior knee surgery in his testimony and notes that a Dr. Fahey "rebuilt" his left knee in 1990. Moreover, the same is documented in the MRI that was completed in May of 2009 as well as the subsequent records of Dr. Freedberg and the medical opinions of Dr. Raab. Nonetheless, it is true that a Petitioner can establish a causal relationship between a pre-existing condition and a work injury if he/she can demonstrate that the work injury was "a cause" of the condition. In assessing whether or not the alleged injury of March 10, 2009 would be considered a cause of Petitioner's left knee injury, the Arbitrator finds it significant that Petitioner's initial presenting complaints to Dr. Levin concern the left lateral thigh and hip area. Dr. Levin makes only brief reference of Petitioner's knee in relation to a hook hitting the same. There is no indication of any "pop" in the left knee and the complaints did not prompt Dr. Levin to request any scanning or diagnostic tests with regard to the left knee.

Although Dr. Belcher diagnosed a knee strain/sprain, she did not evaluate Petitioner until nearly two months after the alleged occurrence. Petitioner advised Dr. Levin on May 19, 2009 that all of his leg pain had resolved. Although Petitioner did make reference to knee pain on August 11, 2009 as of November 24, 2009, Dr. Levin had discharged Petitioner from care to return as needed.

Petitioner offers the opinion of Dr. Howard Freedberg, the surgeon who performed Petitioner's left knee replacement surgery on June 11, 2012 who noted "[t]his is a 56-year-old male who had prior surgery and was actually doing well until a workman's compensation accident, where the accident exacerbated his preexisting degenerative joint disease." Dr. Freedberg does not provide any explanation as to this opinion. More importantly, Dr. Freedberg also opined that Petitioner's low back complaints and radicular complaints were related to the injury as well. However, the record reflects that Petitioner was never alleging any aggravation of the back condition. In fact, Petitioner reported to Dr. Belcher (a treating doctor) and Dr. Zelby (a Section 12 examining physician) that the low back and radicular complaints had been present since 1993 as a result of a prior surgery. That is, Dr. Freedberg appears to have clearly offered his "opinions" of causal connection without actually considering the complaints in the context of the actual history or circumstances alleged.

The Arbitrator adopts Dr. Raab's opinions with respect to causation. Dr. Raab opined that Petitioner's diagnosis was severe degenerative arthritis of the left knee which was clearly documented at the time of the alleged injury in 2009. According to Dr. Raab, the surgery was not causally related to the March 10, 2009. (P 10). Dr. Raab noted that the MRI taken approximately two months after Petitioner's work injury showed evidence of exposed bone and severe degenerative arthritis of the lateral compartment. (P 10). Dr. Raab further noted that the MRI showed no evidence of the prior ACL reconstruction. Dr. Raab testified that, "You couldn't even see a remnant of the reconstruction. This was chronic. It was long standing." (P 12). The doctor testified that the Petitioner's complaints as of the date of the his IME evaluation (October 28, 2011) "were simply the natural progression of his severe degenerative arthritis in his knee and that was preexisting and present prior to his work-related injury of March 10, 2009." With regard to any potential aggravation, Dr. Raab noted, "Whatever injury, if there was one, that he sustained was temporary aggravation of his knee, at most. I believe that he had preexisting arthritis based on a review of the records and would have required this knee replacement with or without whatever work-related injury that he sustained."

At most, it appears that Petitioner experienced a left thigh or hip sprain as a result of the alleged accident. As of May 19, 2009, Dr. Levin stated that Petitioner's leg pain had completely resolved. As

such, the Arbitrator finds that Petitioner simply suffered a temporary sprain resulting in no permanent injuries as a result of the alleged accident of March 10, 2009.

In relation to nature and extent of the injuries, the Arbitrator finds as follows:

Having determined that Petitioner merely suffered a temporary sprain injury, the Arbitrator finds that Petitioner did not suffer any permanency as a result of the alleged accident of March 10, 2009.

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 Reder,
Petitioner,
vs.

NO: 11WC 15829

Sysco Chicago,
Respondent,

16IWCC0412

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 3, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: JUN 17 2016
o042116
DLG/mw
045

David L. Gore

Mario Basurto

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REDER, MICHAEL
Employee/Petitioner

Case# **11WC015829**

11WC015828

16IWCC0412

SYSCO CHICAGO
Employer/Respondent

On 8/3/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
DAVID Z FEUER
1 N LASALLE ST SUITE 2600
CHICAGO, IL 60602

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

16IWCC0412

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

Michael Reder
Employee/Petitioner

v.

Sysco Chicago
Employer/Respondent

Case # **11** WC **15829**

Consolidated cases: **11 WC 15828**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **October 15, 2014 and November 3, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [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 **March 23, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**56,077.32**; the average weekly wage was $**1,078.41**.

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

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

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

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

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

ORDER

The Arbitrator finds that Petitioner has failed to sustain his burden with respect to accident and causal connection. As such, the Arbitrator denies any and all claim for 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

7/30/15
Date

AUG 3 - 2015

16IWCC0412

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHAEL REDER,
Petitioner,

v.

Case No: **11 WC 15829** consolidated with 11 WC 15828

SYSCO CHICAGO,
Respondent.

ADDENDUM TO THE DECISION OF ARBITRATOR

On October 15, 2014 and November 3, 2014, this matter proceeded to hearing pursuant to Section 19(b) of the Illinois Workers' Compensation Act (the "Act") before Arbitrator Jessica A. Hegarty in Chicago, Illinois.

Petitioner filed two claims that were consolidated for trial. The Arbitrator has issued a separate decision for 11 WC 15828.

The disputed issues with respect to 11 WC 15829 are accident, causal connection and the nature and extent of the injury.

STATEMENT OF FACTS

Petitioner worked as a shuttle driver for Respondent, Sysco Chicago. Petitioner's duties included pulling trailers from a warehouse location to a domicile. In connection with the same, Petitioner would hook up the trailers to the trucks.

Petitioner's first claim: 11 WC 05828

Petitioner worked as a shuttle driver for Respondent, Sysco Chicago. His duties included hooking up trucks to trailers and pulling the trailers from a warehouse location to a domicile. On the date of accident Petitioner was 53-years-old. (Id.)

On March 10, 2009, Petitioner was involved in an undisputed accident while lifting a device called a "bogy" off a lead trailer. Petitioner testified that as he was lifting the bogy off a pintle hook, he felt a sharp pain in his left knee and what "felt like a pop." Petitioner testified that he also felt pain in the center of his thigh. Petitioner sought initial treatment at Alexian Brothers Hospital and then followed up with Dr. Mark Levin.

On March 31, 2009, Dr. Mark Levin of Barrington Orthopedics noted that Petitioner presented for an initial consult at which time he noted an accident history consistent with Petitioner's trial testimony.

Petitioner reported feeling severe left lateral leg pain in conjunction with the accident. Petitioner reported that he had "a little injury" to the medial aspect of his proximal tibia when the hook hit him there. Dr. Levin noted that Petitioner's "lateral thigh pain appears to be related to hip pain and may be related to a labral tear versus degenerative hip arthritis". Dr. Levin recommended a left hip arthrogram MRI and released Petitioner to light duty, sitting only work.
On April 9, 2009 a left hip arthrogram MRI was performed and interpreted as unremarkable. On April 21, 2009, Petitioner presented to Dr. Levin who noted that the MRI showed no evidence of a labral tear or significant hip arthritis. Dr. Levin referred Petitioner to Dr. Brooke Belcher of Physical Medicine for evaluation.

On May 7, 2009, Petitioner presented to Dr. Belcher who noted Petitioner's report that he felt a severe "tearing" pain in the left lateral thigh in conjunction with the accident. The doctor noted Petitioner's "previous left hip and thigh pain has completely resolved, however his knee pain has remained." Petitioner reported feeling that his left leg is likely to "give out" at times and he had been using a cane for support. Dr. Belcher diagnosed a knee sprain/strain injury.

On May 15, 2009, Petitioner underwent an MRI of the left knee that was interpreted as showing:

1. Severe osteoarthritis with synovitis and chondralmalacia patellae and chondralmalacia articular cartilage trochlear groove;
2. Status post ACL repair with allograft that no longer demonstrated consistent with complete tear and mild sprain of the posterior cruciate ligament;
3. Chronic attenuation in the medial and lateral retinaculum with labral subluxation of the patella;
4. Grade II sprain medial collateral ligament and intermediate grade sprain of the collateral ligament;
5. Degenerative signal posterior horn of the medial meniscus without definite evidence of a tear;
6. Degenerative type complex tear involving posterior horn body and anterior horn lateral meniscus with lateral extrusion of the body of the lateral meniscus and;
7. Mild muscle strain of the medial head of the gastrocnemius muscle and contusion and hairline fracture lateral tibial plateau.

On May 19, 2009, Petitioner followed up with Dr. Levin who noted that "Mr. Reder has actually resolved all of his left leg pain" and could bend, stoop, squat, and climb. Dr. Levin recommended Petitioner's full duty return to work without restriction. With respect to the left knee MRI, Dr. Levin noted that the MRI shows chronic changes of the knee with osteoarthritic changes and that Petitioner "had an old ACL reconstruction that ruptured a long time ago". The doctor further noted that the MRI revealed "some degenerative changes with some bony contusion to the lateral tibial plateau."

Petitioner returned to Dr. Levin on August 11, 2009, at which time reporting increasing soreness over the left lateral knee when taking less Celebrex. Dr. Levin noted his continued recommendation for full duty work. The last note taken by Dr. Levin, dated November 24, 2009, notes that Petitioner had done quite well and was able to work full duty. Dr. Levin stated that Petitioner was at maximum medical improvement.

Petitioner testified that he returned to work on April 26, 2009 to light duty employment and to full duty employment thereafter.

Petitioner testified that he had previously seen a Dr. Fahey, who "rebuilt" his knee in 1990. Petitioner states that he was "working okay" from 1990 until 2009. Petitioner denied any treatment to his knee until the March 10, 2009, accident.

11 WC 05829

Petitioner testified that on March 23, 2011, he noticed pain in his left leg and knee when stepping out of his truck at the end of his shift. Petitioner states that he had gone from a sitting position to a standing position and was on the step of his truck when he stood up and experienced pain. Petitioner then climbed down the truck and continued to experience pain. He noted that he was at the Crystal Lake location and in a lot that had a gravel surface. Petitioner states that after he noticed the pain at the Crystal Lake facility, he phoned the company nurse, Debbie Valleskey.

Petitioner testified that earlier in that shift, he made two trips to the Bolingbrook facility. At Bolingbrook, he walked between the trucks. He testified that the surface was only dirt without any gravel and that the same was wet. Petitioner alleges that he "got physically stuck in the mud" and had to pull his legs out.

Respondent presented testimony from Ms. Debbie Valleskey, a nurse who works for Respondent. Ms. Valleskey confirms that Petitioner did phone him on the alleged accident date. Ms. Valleskey testified that Petitioner did not report any specific episode and never described the onset of pain when rising from a sitting position in his truck. Ms. Valleskey states that she had two conversations with Petitioner that date. In the second conversation, Petitioner reported that he had noticed prior episodes of pain in the left knee and had attempted to see his primary care physician with regard to the same.

Respondent submitted as Exhibit Number 5, the notes identified by Debbie Valleskey with regard to her conversations with Petitioner following the alleged occurrence of March 23, 2011. The notes indicate that Petitioner reported he had left knee pain and when asked why he had knee pain, Petitioner stated that he had to walk through mud in the Bolingbrook truck yard. Petitioner noted his prior reconstructive knee surgery. The notes indicate that Petitioner reported that he had seen his family doctor for left knee pain on March 4, 2011, but the doctor would not provide medication as he was being treated with antibiotics for another condition. Petitioner stated that he returned to the physician on March 7, 2011, and was told to start Celebrex on March 14. The notes indicate that Petitioner had not reported any specific injury. Petitioner alleged that trailers and "dollies" were sinking in the mud in the yard and further stated that "With each step he takes... another layer of mud gets added to the bottom of his boots and it gets heavier and heavier." Petitioner stated that he had not felt pain prior to that date but also notes that he had an MRI done two years prior.

Respondent submitted as Exhibit Number 6, a triage note from a nurse that Petitioner called on the telephone after his alleged accident. Petitioner reported that he was walking through mud.

Respondent submitted as Exhibit Number 1, the videotape deposition of Richard Leonard and as Exhibit Number 2, the transcript from the evidence deposition of Mr. Leonard. Attached to Exhibit Number 2 is a video footage that Mr. Leonard had recorded of the Bolingbrook yard where Petitioner claimed that his foot became stuck in mud. Mr. Leonard testified that he began working for Respondent in 2001 in a facility in Cleveland and began working in Sysco Chicago in April of 2009. (P 9). Mr. Leonard is a safety and security manager for Respondent, which includes overall responsibility of the safety of everyone in the company, security of the facility and security guards that work in the facilities. (P 11). Mr. Leonard

testified that he had spoken with Petitioner a few days after the alleged incident and notes that Petitioner initially reported injuring himself on March 3rd and then stated that he was hurt on March 23 of 2011. (P 12). Mr. Leonard noted that he felt there were "several miscommunications, there were several things that [Petitioner] had stated that did not make sense and he had made several different conflicting statements." (P 15-16). Mr. Leonard states that Petitioner initially reported that he felt pain in his knee on March 1, 2, and 3 because of walking around a muddied yard in the Bolingbrook domicile. He notes that Petitioner was then off of work for approximately three weeks for FMLA and again alleged re-injury from walking in the muddied yard at the same domicile. (P 17). Mr. Leonard noted that it had been raining the morning that he spoke with Petitioner. According to his testimony, Mr. Leonard immediately went to the Bolingbrook yard to videotape the facilities after his conversation with Petitioner. Mr. Leonard believed that the conversation with Petitioner and the videotaping occurred on March 24, 2011 .

Mr. Leonard described the lot as initially paved and "then once you get half way into the lot, past the truck bay areas, the parking area is a hard gravel type compacted dirt. So it's a very solid type dirt that withstands trucks, fully loaded trucks driving over it every single day." Mr. Leonard noted that during their conversation, Petitioner had alleged that the bogies and the trailers were sinking in the mud. Mr. Leonard testified that he investigated the same and saw no evidence of anything that had sunk in any of the areas where Petitioner worked. (P 19). Mr. Leonard testified that he walked through the entire yard and then videotaped the bottom of his shoe and noted there was no mud on the same. (P 19).

Petitioner testified that after the accident he was sent to the company clinic and denies that there was any examination.

Petitioner testified that a Dr. Fahey, "rebuilt" his knee in 1990 and that he was "working okay" from 1990 until 2009. Petitioner denied any treatment to his knee until the undisputed accident in 2009 (11 WC 15828).

On April 19, 2011, Petitioner presented for an initial consult to Dr. Freedberg who noted the following history:

> "55 Y/O right hand dominant male C/O left knee and thigh pain from work related injury...States he tore ACL reconstruction in 1990. States two years ago at work, 3/10/09, lifting something heavy, felt sharp pain in left knee, mostly on the outside with pain shooting up lateral side of thigh to hip. Went to Alexian Bros, then followed up with Dr. Levin at Barrington Ortho, ordered MRI of hip and knee, put on Celebrex, off work for seven weeks, light duty after. Released for full duty until August 2009. Worked from then until present, 3/23/11, driving a semi hauling trailer. States he has to get under the truck to check connections with trailer. States he was walking in mud/clay, got stuck under the truck, straining to get unstuck. By the end of shift, tried to get out of truck. Got stabbing pain on the outside of knee and center of anterior thigh." (PX 1b)

Petitioner treated conservatively with physical therapy and injections until June 11, 2012, when Dr. Howard Freedberg performed left knee replacement surgery. (PX 1A) The indications for surgery on the operative report are noted as, "[t]his is a 56-year-old male who had prior surgery and was actually doing well until a workman's compensation accident, where the accident exacerbated his preexisting degenerative joint disease."

Petitioner submitted as Exhibit Number 2, records from Sherman Hospital concerning his knee replacement surgery. The notes indicate that Petitioner remained in the hospital through June 14, 2012 and returned on June 15 with an apparent infection.

Petitioner testified that the knee replacement surgery "was the best thing I ever did for myself". When asked on cross-examination specifically as to whether or not he had continued pain after the first surgery in 1990, Petitioner answered that he felt doing physical work for 19 years began breaking down the condition "and over a period of time, yeah, you become sore and it progresses more and more."

Dr. Raab 10/28/11 IME

Respondent submitted as Exhibit Number 4, the evidence deposition of Dr. Raab completed on September 30, 2013. Also attached to the transcript was Dr. Raab's report from an evaluation of October 28, 2011. Dr. Raab noted that he was asked by Respondent to address whether or not Petitioner's condition in his left knee was related to an accident described on March 10, 2009 and/or an accident described on March 23, 2011. (P 9). Dr. Raab testified that Petitioner's diagnosis was severe degenerative arthritis of the left knee which was clearly documented at the time of the alleged injury in 2009. Dr. Raab opined that the treatment and knee replacement surgery was not causally related to the alleged injury of March 10, 2009, nor was it causally related to the alleged injury of March 23, 2011. (P 10). Dr. Raab noted that the MRI in 2009 showed evidence of exposed bone and severe degenerative arthritis of the lateral compartment. (P 10). Dr. Raab stated that the Petitioner's complaints as of the date of the evaluation (October 28, 2011) "were simply the natural progression of his severe degenerative arthritis in his knee and that was preexisting and present prior to his work-related injury of March 10, 2009." With regard to any potential aggravation, Dr. Raab noted, "Whatever injury, if there was one, that he sustained was temporary aggravation of his knee, at most. I believe that he had preexisting arthritis based on a review of the records and would have required this knee replacement with or without whatever work-related injury that he sustained." Moreover, Dr. Raab noted that there was no ACL reconstruction present on the MRI from 2009. In addressing the same, Dr. Raab states, "He had severe arthritis. You couldn't even see a remnant of the reconstruction. This was chronic. It was long standing." (P 12). Dr. Raab further explained that the ACL reconstruction had failed prior to March of 2009. (P 13).

Dr. Zelby 4/25/12 IME

Respondent submitted as Exhibit Number 3, the evidence deposition of Dr. Andrew Zelby completed on April 25, 2013. Dr. Zelby is a board certified neurosurgeon licensed to practice medicine in the State of Illinois. (P 4-5). Dr. Zelby examined Mr. Reder on April 25, 2012. Dr. Zelby indicated that Petitioner provided a history of having lifted the front end of a bogy with about 75 to 100 pounds of force and hearing a pop in his left knee. (P 7). Petitioner told Dr. Zelby that he experienced severe left knee pain and pain along the outside of the knee joint and burning along the bottom of the knee. (P 8). Dr. Zelby notes that Petitioner then reported that on March 23, 2011, he noticed the same type of "stabbing pain" in the left knee and burning along the bottom of the knee which he attributed to walking in mud approximately an hour earlier. Petitioner reported to Dr. Zelby that he had a history of aching pain in the low back with pain radiating down the back of the left thigh and posterior and lateral aspect of the foreleg into the lateral aspect of the foot since 1993. He also noted a history of back surgery in 1993. (P 8). Dr. Zelby stated that Petitioner "felt that he had no problems with his low back different from his usual symptoms since he recovered from surgery in 1993." (P 9). Dr. Zelby noted that he reviewed a

number of medical records that pertained mostly to complaints about the left thigh and knee. (P 11-12). Dr. Zelby also reviewed a note of Dr. Freedberg who added a diagnosis of a left lumbar radiculopathy and lumbar degenerative disc disease, opining that Petitioner's injury was a contributing cause to the low back problems. (P 13).

Dr. Zelby diagnosed Petitioner with a lumbar radiculopathy and a lumbar discectomy. (R 13). Dr. Zelby concluded that Petitioner had reported two injuries at work and there was no evidence for any complaints of back pain or report of injury to his back in connection with either of the alleged incidents. (P 13-14). Dr. Zelby stated that, "[c]ontrary to Dr. Freedberg's records, Petitioner "made it clear to me that he had the same problem that he had all along and it was obvious that the patient didn't think it was a contributing factor." Dr. Zelby stated that the exam was consistent with chronic S1 radiculopathy that was neither caused, aggravated, exacerbated or accelerated by the alleged accidents. (P 14).

CONCLUSIONS OF LAW
CASE NUMBER 11 WC 15829

In relation to accident and causal connection, the Arbitrator finds as follows:

In assessing this issue, the Arbitrator finds that evidence in the record with respect to how this accident occurred is inconsistent and confusing.

Petitioner's testimony alleges an onset of symptoms when getting up from a seated position while in his truck. Petitioner's testimony also alleges that his foot became stuck in mud and he had to pull his leg from the mud. Richard Leonard videotaped the entire lot shortly after the occurrence. Although there is standing water on the lot, the lot is clearly made of a crushed gravel-like substance that is packed and does not create the muddy surface as described by Petitioner. Certainly, it would make no sense for a yard where heavy equipment is moved to be surfaced with mud that would result with sliding equipment and equipment becoming stuck. The videotape completed by Mr. Leonard clearly shows that there was no accumulation of mud while walking through the lot. To say the least, it would seem unlikely that large semi-trucks would be able to come and go during any periods of rain if the lot was simply dirt. Moreover, there are no apparent ruts or indentation in the lot. There do appear to be some slight depressions as there are some areas of standing water. Nonetheless, Mr. Leonard did walk through the entire area of the lot and taped the bottom of his shoes while doing so. There was no mud attached to the shoes.

As noted above, Petitioner's testimony was not that he noticed any increase in pain at the time he alleges he pulled his foot from any mud. Instead, he continued working, drove from Bolingbrook to Crystal Lake and states that he noticed pain when simply standing up from the seat of his cab. Ms. Valleskey states that when Petitioner phoned her, he made no mention of any onset of pain when getting up from his seat. Ms. Valleskey states that Petitioner did allege that the condition of the lot was muddy. He did not, however, allege any specific episode of pain.

Respondent submitted as Exhibit Number 6, a triage note from a nurse that Petitioner called on the telephone after his alleged accident. Petitioner reported that he was walking through mud. The Arbitrator notes that Petitioner makes no reference to noticing pain upon rising from a sitting position to exit his truck.

The two medical opinions submitted with regard to the left knee condition were provided by Dr. Raab, Respondent's Section 12 examining physician, and Dr. Freedberg, Petitioner's treating physician. Dr. Raab notes that Petitioner had a bone on bone condition in the left knee as a result of the prior surgery. Dr. Raab noted that the ACL was not present in reviewing the imaging studies. He states that the ACL reconstruction from the past had failed long before 2009.

Dr. Freedberg simply indicates that the alleged injuries constituted "a cause" of Petitioner's need for a knee replacement surgery. Dr. Freedberg does not provide any explanation as to this opinion. More importantly, Dr. Freedberg also opined that Petitioner's low back complaints and radicular complaints were related to the injury as well. However, the record reflects that Petitioner was never alleging any aggravation of the back condition. In fact, Petitioner reported to Dr. Belcher (a treating doctor) and Dr. Zelby (a Section 12 examining physician) that the low back and radicular complaints had been present since 1993 as a result of a prior surgery. That is, Dr. Freedberg appears to have clearly offered his "opinions" of causal connection without actually considering the complaints in the context of the actual history or circumstances alleged.

Petitioner clearly had a pre-existing condition involving the left knee as is noted in the companion case herein (11 WC 15828). Dr. Raab opined that Petitioner's need for a knee replacement is not related to any alleged work occurrence of March 10, 2009 or March 23, 2011. Dr. Raab explains that the MRI in March of 2009 showed bone on bone degenerative arthritis. Moreover, he noted that the prior ACL surgery had failed "long before" in the alleged incident in March of 2009. According to Dr. Raab, Petitioner's left knee condition and the need for knee replacement surgery is the result of a natural progression of Petitioner's significant underlying degenerative arthritis.

Dr. Raab's opinions in this regard are supported by the history of complaints and Petitioner's statements regarding his left knee condition. Of most significance, it is noted that Petitioner testified that his left knee replacement was "the best thing" he had ever done. When Petitioner did have the knee replacement completed, he voiced that he should have pursued the same "a long time ago." On cross-examination, Petitioner admitted that after the prior knee surgery in 1990, his knee started to break down "over a period of time" and became "sore and progressed more and more." That is, although Petitioner was reportedly able to work, it is clear that he simply continued to experience a progression of his symptoms overtime.

Based upon the above, Arbitrator finds Dr. Raab's opinions to be more credible and persuasive than Dr. Freedberg's. Namely, the Arbitrator finds that Petitioner's left knee condition and the need for the left knee replacement surgery simply represented a natural progression from his prior knee surgery which appears to have failed. Furthermore, the Arbitrator finds that the alleged work injury did not cause, aggravate or accelerate Petitioner's left knee condition.

Having determined that Petitioner's left knee condition is unrelated to any work accident or activity of March 23, 2011, the Arbitrator finds all other issues to be 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 Williams,

Petitioner,

vs. NO: 15 WC 11573

16IWCC0413

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 12, 2015, is hereby affirmed and adopted.

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

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

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

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

DATED: JUN 17 2016
O051916
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

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

WILLIAMS, JAMES
Employee/Petitioner

Case# **15WC011573**

16IWCC0413

ACE COFFEE BAR INC
Employer/Respondent

On 11/12/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5625 PAUL W GRAUER & ASSOCIATES
ANDREW J KRIEGEL
1300 E WOODFIELD RD SUITE 205
SCHAUMBURG, IL 60173

4412 ACCIDENT FUND HOLDINGS, INC
NICOLE B HANLON
200 W MADISON ST SUITE 3850
CHICAGO, IL 60606

16IWCC0413

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 WILLIAMS
Employee/Petitioner

v.

ACE COFFEE BAR, INC.
Employer/Respondent

Case # **15** WC **11573**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maria S. Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **10/1/15**. 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. ☒ 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 **Future Medical Treatment**

FINDINGS

On the date of accident, **2/2/15**, 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 **$39,603.20**; the average weekly wage was **$761.60**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **2** dependent children.

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

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

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

ORDER

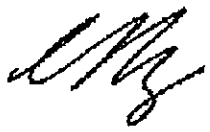
Respondent shall pay for and authorize for the lumbar epidural steroid injections recommended by Dr. Espinosa, along with all incidental medical care thereto.

Respondent shall reimburse Petitioner **$780.00** for out of pocket monies spent pursuant to the findings of fact attached herein. Respondent shall pay directly to Petitioner the remaining outstanding medical bill balance of $2,307.00 pursuant to the findings of fact attached herein. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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



Signature of Arbitrator

11-12-15
Date

FINDINGS OF FACT

James Williams ("Petitioner") testified, without contradiction, that he was an employee of Ace Coffee Bar, Inc. ("Respondent") on 2/2/15. On that date, he testified he worked as driver for Respondent, whose company was in the business of supplying various vending items and coffee to other businesses. Part of his duties included driving his route, unloading the supplies and delivering them to companies. He testified the number of stops he makes varied and that some stops have multiple deliveries, but that he would estimate that he makes between eight to twenty deliveries per day. He testified he normally does not have a helper to help make deliveries.

On the date he worked, he began his shift at 2am and he testified there was around 19 inches of snow. He testified work was difficult in trying to get the supplies through unplowed areas to the businesses. He recalled that the streets and sidewalks had not been cleaned or shoveled. He further testified that delivering the vending merchandise to the locations in the snow made his route twice as difficult. He recalled he made a delivery to Amtrak. He said nothing was plowed and he could not push a cart through the snow. Instead, he packed up as much as he could, about 3 tubs, and carried it about 2 blocks. He estimated it weighed 75 pounds.

Petitioner testified that at another one of his stops he had to deliver sandwiches and drinks to replenish the vending machines. Petitioner testified that at this stop the snow was so deep that he left the delivery truck in the middle of Kedzie Avenue, put the products on a dolly and pulled the load in because he was unable to push the loaded dolly through snow. He said he did this for 1.5 blocks.

Petitioner testified he was exhausted and sore after finishing his route on 2/2/15. He testified that night he went home thinking his soreness would go away the next morning after he rested but he said his back got worse the next day. He said his soreness was located in his back and was shooting down the left leg. Petitioner went to work Tuesday morning. At that time he did not report his back pain to his supervisor, because he hoped the pain would go away with aspirin, rest and a hot shower. Petitioner testified his pain did not improve.

Petitioner testified that he reported to his supervisor on Wednesday morning that he was injured. Petitioner testified his supervisor understood the way they work and the way the work was and further understood he was injured from work the day before. Petitioner testified he asked for help completing his routes and was given Bob to help him on Wednesday. Petitioner testified he also told Bob he was injured. Petitioner testified he asked for help Thursday but help was not available and his work took longer. Bob helped Petitioner again Friday and he testified Bob did the entire route for him.

Petitioner testified that when he went home that weekend, he rested and hoped his back pain would improve with rest. He testified that his back pain did not improve over the weekend, and that his back pain was so severe he was forced to call in. He testified that on Monday 2/9/15, he called his supervisor Barry to call in due to back pain. Petitioner said he was then contacted by Jim Martin, his route Manager, who advised him to contact Jamie, the human resource representative for Respondent. Petitioner testified he spoke with Jamie and told her that he hurt his back. He understood she would email an incident form for him to complete. He testified she did not explain how to fill it out but only said that certain parts needed to be filled out. Petitioner testified he completed the form and sent it back. Px14, Rx1. In it, he wrote that he was injured on 2/3/15 on a Tuesday and that at the time, he was doing his normal job functions. He also wrote that he injured himself while doing his route and that pain started in his back working its way down to his legs. He wrote that he was restricted from working by a physician due to medications. He signed the document 2/13/15. *Id.* Petitioner testified that on that Monday, he also called his doctor to make an appointment.

On 2/9/15, Petitioner saw Dr. Patel. Px4, Rx3. Dr. Patel wrote that Petitioner presented with acute low back pain for the past week after almost 1 year. He noted Petitioner complained of left sided low back since last Tuesday and that he normally didn't shovel snow but had to dig his car out. Symptoms included severe low back pain with radiation down the left leg. Symptoms were exacerbated with walking upright and Petitioner noticed a burning sensation of the distal leg and thigh intermittently. Exam of the back showed stiffness near the lumbar spine and restricted straight leg raise due to severe pain. Petitioner was diagnosed with low back pain and left sided radicular symptoms. He was prescribed medications.

Petitioner testified that at that appointment Dr. Patel did not spend much time examining him and that most of the examination and history was taken by Dr. Patel's nurse or assistant. Petitioner testified that he never told Dr. Patel's nurse that he hurt his back shoveling snow. Petitioner testified he explained to Dr. Patel's nurse about his pain coming on while performing his route at work. Petitioner testified he was not aware of any discrepancies in Dr. Patel's medical record. He also testified that he had a phone conversation with Dr. Patel regarding shoveling snow and that Petitioner asked Dr. Patel "where did you get that?"

Petitioner was seen at Adventist Bolingbrook for MRI. Px4, Px5, Rx3. Under "accident information," no information was listed. MRI of the lumbar spine showed degenerative changes throughout. At L2-3, right paracentral disc extrusion effacing the right lateral recess likely affecting the L3 nerve root was noted. At L5-S1, tiny central disc protrusion was noted. Moderate right L2-3, severe right L3-4 and bilateral L4-5 and right L5-S1 neural foraminal stenosis was noted.

On 2/20/15, Petitioner saw Dr. Francisco Espinosa at the referral of Dr. Patel. Px4, Px6, Rx3. Hand written intake forms noted that "on 2/2/15 Tuesday during the day at work my back started slowly to become more and more painful walking and standing." Px6. Hand written notes also indicated that Petitioner had been off of work since 2/7/15 due to pain the leg and back. The doctor noted that on 2/2/15, Petitioner was lifting and injured his back and started to have left leg pain. He noted that the symptoms progressed as the day wore on. The doctor noted prior history of herniated disc at L3-4 in 2005. Petitioner testified that he explained to Dr. Espinosa how he hurt his back pulling his heavy cart through the snow at work. Exam showed antalgic gait, decreased range of motion, left sciatic notch tenderness, normal heel-toe walk, negative sitting straight leg raise, normal lower extremity strength, intact sensation and 1+ reflexes. The doctor noted that the main source of Petitioner's pain was the stenosis giving rise to neurogenic claudication, which mean although there may be normal physical exam, symptoms develop when standing or walking. Lumbar injections were ordered. Dr. Espinosa diagnosed L4-5 stenosis. Px6.

On 3/11/15, Dr. Scott Glaser performed a left L4-5 and L5-S1 transforaminal epidural steroid injection at the referral of Dr. Espinosa. Px6-8. Dr. Glaser noted that Petitioner's low back pain was precipitated by a work related accident. Petitioner first noticed his pain on 2/2/15 and that it progressively became worse. *Id.* Petitioner complained of severe low back pain radiating to the buttock and leg on the left, left ankle/foot pain with pain and throbbing and gradual right thigh pain with rare numbness. Exam showed mildly tender right lower, left lower and left mid region facets. Left straight leg raise elicited buttock pain. Dr. Glaser diagnosed lumbar radiculopathy and lumbar facet syndrome without myelopathy. *Id.* Petitioner testified the injection brought temporary relief. Petitioner testified he only underwent one epidural injection because each shot cost him $500.00 out of his own pocket since the workers' compensation carrier was not paying any of his medical bills. On 3/17/15, Joe Kautz of Third Coast Underwriters notified Petitioner that his workers' compensation claim was denied based on an investigation and after concluding no accident or injury occurred at work. Rx2.

Petitioner stopped receiving medical treatment in March of 2015 since he was paying for the treatment out of his own pocket. He went back to work after his worker's compensation claim was denied. Petitioner testified he stopped receiving medical treatment at that time because he could not afford to take time off work or pay for the treatment himself. Petitioner testified that he continues to have back pain in his lower back. He testified that this back pain is so severe when he walks; he feels the pressure building up in his lower spine. Petitioner has to sit or bend forward to feel better. Petitioner testified that to this day he continues to experience shooting pain down his left leg.

Petitioner testified he had a previous back surgery about twelve years ago. He testified that, prior to 2/2/15; he had no problems with his back other than the occasional soreness since the prior surgery. Petitioner testified he wants to get his back fixed, and that he wants to get the further medical treatment that Dr. Espinosa has recommended. On cross, he admitted that technically no one authorized him off of work and that no one told him to stay home. On cross, Petitioner testified he knew who Joe Kautz was and he recalled talking to him many times. Petitioner admitted he was somewhat vague in describing his injury.

Joe Kautz ("Kautz") testified on behalf of Respondent. Kautz testified he was the assigned claims adjuster for Petitioner's claim. Part of his duties required investigating work injury claims. He stated that on 2/12/15, the claim was assigned to him and that as part of his investigation; he contacted the employer, Petitioner and medical providers. Kautz recalled he spoke with Petitioner around 2/13 and that he obtained consent to take Petitioner's recorded statement. He recalled Petitioner stated he reported gradual onset of back pain and nothing specific about an accident. Kautz said the recorded statement was then transcribed, which he identified as Rx4. In that statement, Kautz took down Petitioner's job duties. *Id.* Petitioner told Kautz that his injury slowly came on and that his back was tightening up and starting to hurt as the day progressed. Petitioner told Kautz that it was not like he got hit by a car. Petitioner told Kautz he went home and tried to shake it off and the next day his back still hurt so he asked for help. Petitioner described pain in the lower spine, buttocks and down the front of his shin and ankle. When asked whether his injury was from an accident, Petitioner stated that it could have been work related but that he knew if he filed workers comp, he would be eliminated. Kautz stated he completed his investigation, denied the claim and notified Petitioner. Rx2.

CONCLUSIONS OF LAW

The Petitioner bears the burden of proving every aspect of his claim by a preponderance of the evidence. *Hutson v. Indus. Comm'n*, 223 Ill. App. 3d 706, 585 N.E.2d 1208 (1992). Liability under the Act may not be based on imagination, speculation, or conjecture but must have a foundation of facts established by a preponderance of the evidence..." *Shell Petroleum Corp. v. Indus. Comm'n*, 366 Ill. 642, 10 N.E. 2d 352 (1937). Preponderance of the evidence means greater weight of the evidence in merit and worth that, which has more evidence for it than against it. *Spankroy v. Alesky*, 45 Ill. App. 3d 432, 359 N.E.2d 958 (1st Dist. 1977).

Here, Petitioner's unrebutted testimony was that he injured himself at work on 2/2/15 while making deliveries for Respondent following a heavy snow fall. The Arbitrator takes judicial notice that 2/2/15 was a Tuesday. He testified that his shift began at 2 am, a time when sidewalks and roads were not yet plowed. He testified he was forced to load up the materials and either carry and/or pull them through the snow. During this shift, he began to experience low back pain that gradually increased. The next day, Wednesday 2/3/15, he reported his onset of low back pain after making his work deliveries the shift prior. Petitioner's unrebutted testimony was that Respondent gave him help from Bob to help make deliveries for Wednesday 2/3/15. He testified that he worked on Thursday 2/4/15 and was not given help as no help was available. On Friday 2/5/15, he was again given help make deliveries due to his back pain. Records show Petitioner worked Saturday 2/6/15. Rx4. Petitioner testified that he called in sick due to his low back pain on Monday, which would have been

2/8/15. He said he called Dr. Patel that same day to make an appointment. Petitioner testified the he was advised to contact Jamie from HR and that she eventually emailed him a report to fill out.

On 2/9/15, Dr. Patel wrote that Petitioner related shoveling snow as that source of his back pain. Petitioner testified that he saw Dr. Patel briefly and spoke mostly with the doctor's assistant. Petitioner testified that he did not tell Dr. Patel he was injured shoveling snow but that he was injured while working his route in the snow.

Kautz testified that on 2/12/15, he was "assigned" Petitioner's claim. The Arbitrator finds this part of Kautz's testimony as key in helping to determine whether the preponderance of the evidence establishes Petitioner's credibility and consistency. In the Arbitrator's view, if Kautz was "assigned" the claim on 2/12/15, it would have been because someone from Respondent initiated the filing of a workers' compensation injury and/or claim with its carrier ***prior to*** the 2/12/15 date in which Kautz says the claim was assigned. This conclusion is supported by Petitioner's testimony that he had conversations with his supervisor, Barry, Jim Martin and Jamie from HR, all whom Petitioner identified as working for Respondent. While it was not clear who of all the people Petitioner spoke with exactly initiated the claim, the evidence most likely suggests the claim was initiated by Jaime of HR on behalf of Respondent. This is supported by the recorded statement wherein Kautz identifies and suggests Jaime as the individual Petitioner may have reported to. Rx4. That Kautz identified Jaime of his own volition indicates to the Arbitrator that the claim was initiated most likely by Jaime and that Jaime made contact with Kautz at some point.

In addition, that the claim was likely initiated prior to the 2/12 assigned date informs the Arbitrator that it is also likely that Petitioner was having or attempting to have a very similar conversation about his accident with Dr. Patel. This conclusion is also supported by Petitioner's trial testimony that when he had a phone conversation with Dr. Patel regarding the history of his injury, he was confused as to where Dr. Patel obtained information regarding shoveling snow. The Arbitrator is persuaded this conversation did in fact take place as Petitioner mentioned a phone conversation with Dr. Patel himself during the recorded statement to Kautz. Rx4:9. While this analysis is not evidence of admission of liability or evidence of accident, it does demonstrate Petitioner's credibility and consistency in that saying that he reported a work accident to both Respondent and the initial treating doctor, Dr. Patel. This conclusion is also supported by the treating records of Drs. Espinosa and Glaser.

Petitioner's history of accident is further corroborated and consistent in the treatment records of Drs. Espinosa and Glaser. On 2/20/15, the hand written intake forms in the Espinosa medical recorded noted that on 2/2/15 on a Tuesday Petitioner's back started hurting while at work and became more painful. Px6. The Arbitrator finds this consistent with Petitioner's trial testimony that his back began to hurt and get worse while making his deliveries at work. Espinosa wrote Petitioner injured his back while lifting and that he started to have left leg pain and that it progressed as the day wore on. Although this record does not explicitly mention work, the Arbitrator can reconcile this with Petitioner's hand written intake form to Espinosa, along with all other evidence, in favor of Petitioner. Espinosa noted the pain became worse as the day wore on, which in the Arbitrator's view is consistent with Petitioner's testimony that his back pain got worse during his shift, consistent with Petitioner's statement to Kautz that his back pain got worse, consistent with Petitioner's statement to Dr. Glaser that his pain became progressively worse. Read together, the preponderance of the evidence supports Petitioner's statement that he told Espinosa about a work accident.

In addressing potential inconsistencies in Petitioner's history of events, the Arbitrator notes that in Petitioner's recorded statement to Kautz, he appears to mistakenly identify his Tuesday work occurrence as February 3rd and immediately thereafter, Kautz appears to correct Petitioner, asking "...2, 2015, right?"

Petitioner also believed the Tuesday of his incident was on 2/3/15 in his incident report. Px14. In addition, Petitioner believed the Monday he called in was the 9th, stating "the 9th or something like that." Rx4. Petitioner also mistakenly believed he first saw Dr. Patel on Monday 2/9. However, Monday would have been 2/8, when Petitioner called in sick and when he said he made a doctor's appointment. On 2/9, when Petitioner actually saw Dr. Patel, that would have been a Tuesday. The record demonstrates Petitioner may have been confused. The Arbitrator finds this are harmless errors in assigning a day of the week with a date and the evidence most clearly establishes his accident occurring on a Tuesday, 2/2/15.

Having found Petitioner's history of accident and timeline credible, consistent and corroborated by various records, the Arbitrator concludes Petitioner has also established by a preponderance of the evidence that he sustained an accident arising out of and in the course of his employment with Respondent. Petitioner's consistency and credibility regarding the history of accident and his timeline of reporting is sufficient to overcome the only record in evidence that is different than all others, that of Dr. Patel's.

In the context of accident, to obtain compensation under the Illinois Workers' Compensation Act, an employee must show by a preponderance of credible evidence that he suffered a disabling injury arising out of and in the course of his employment. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 203, 797 N.E.2d 665 (2003). For an employee's workplace injury to be compensable he must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. It is not enough that Petitioner is working when accidental injuries are realized; Petitioner must show that the injury was due to some cause connected with employment.

Here, Petitioner testified credibly and without contradiction that part of his job duties as a route driver required him to load his delivery truck, unload vending machine supplies from the delivery truck onto dollies and deliver them onsite to various locations. He testified that on the date of his accident, there was a lot of snow on the ground that had not been plowed or removed. Petitioner stated that he completed his deliveries despite the snow, having to load several boxes of supplies and pulling rather than pushing his work dolly to the drop site. He stated that he developed an onset of low back pain while performing these work related tasks and that his low back pain gradually worsened throughout the shift while continuing to complete the work related deliveries. The Arbitrator finds that Petitioner's injuries to his back and the radiation down his leg arose out that employment, having been brought on by the employment duties. This finding is corroborated by the medical records as well as other evidence already discussed. In light of the foregoing, the Arbitrator concludes Petitioner has proven by a preponderance of the evidence that he sustained an accident on 2/2/15 arising out of and in the course of his employment with Respondent.

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

Having found in favor of Petitioner on the issue of accident, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence, under a chain of events theory, that his lumbar spine injuries at L4-5 and L5-S1, are causally related to his work accident. In support thereof, the Arbitrator relies on Petitioner's testimony and the medical opinions of Drs. Espinosa and Glaser.

Medical evidence is not an essential ingredient to support the conclusion that an industrial accident caused the disability. A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. When the claimant's version of the accident is uncontradicted and his testimony unimpeached, his recital of the facts surrounding the accident may be sufficient to sustain an award. *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 442 N.E.2d 908 (1982). In the instant case, Petitioner

testified that he had no immediate prior low back injuries or problems leading up to his date of accident. He candidly admitted at trial, to Kautz in his recorded statement and to his treating doctors that he had a prior L3-4 surgery, which was treated and resolved. The Arbitrator notes that the L3-4 disc level was not implicated as a symptomatic level by Petitioner or by his doctors as a result of the 2/2/15 work accident. Immediately following the work accident, Petitioner complained of low back pain with radiation to the left leg.

In those treatment records, Dr. Espinosa recorded that Petitioner's back pain began after lifting. Dr. Glaser noted that Petitioner's low back pain was precipitated by a work related accident. Px6-8. The Arbitrator finds these statements supportive of causation under a chain of events theory.

ISSUE (J) Were The Medical Services That Were Provided to the Petitioner Reasonable and Necessary? Has the Respondent Paid All Appropriate Charges For All Reasonable and Necessary Medical Services?

Having found in favor of Petitioner on the issues of accident and causation, the Arbitrator finds that Petitioner has proven that the medical treatment he received for his low back following the work accident was as a result of the work accident. Medical records document that the only services received by Petitioner were for problems associated with his work injury. Accordingly, the bills from Northwest Medical Care, Adventist Bolingbrook Hospital, Neurological Surgery and Spine Surgery, Pain Specialists of Greater Chicago and Hinsdale Surgical Center are reasonable and necessary to treat the injury Petitioner suffered in his work injury of 2/2/15. At trial Petitioner alleged outstanding medical balances as unpaid and related to his work accident. Ax1, Px9-13.

Northwest Medical Care	$146.00
Adventist Bolingbrook Hospital	$4,000.00
Neurological Surgery and Spine Center	$471.00
Pain Specialists of Greater Chicago	$2,307.00
Hinsdale Surgical Center	$4,882.00

Regarding the Northwest Medical Care bill, Petitioner was evaluated on 2/9/15, incurring $146.00 in charges for which $111.00 was adjusted off and for which a payment by Petitioner's Humana group health paid in the amount of $35.00. Px9. Therefore, the balance is zero. 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.

Regarding the Adventist Bolingbrook Hospital bill, Petitioner incurred $4,000.00 in charges for which $2,327.00 was discounted, $1,523.00 was adjusted off by Humana and $150.00 paid out of pocket by Petitioner. Px10. Therefore, the balance is zero. Respondent shall reimburse Petitioner **$150.00** for out of pocket monies spent. 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.

Regarding the Neurological Surgery and Spine Center, Petitioner incurred $471.00 in charges for which $291.38 was adjusted, $114.62 was paid by Hinsdale Physicians Healthcare and $65.00 paid out of pocket by Petitioner. Px11. Therefore, the balance is zero. Respondent shall reimburse Petitioner **$65.00** for out of pocket monies spent. 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.

Regarding the Pain Specialist of Greater Chicago bill, Petitioner incurred $2,372.00 in charges for which Petitioner paid $65.00 paid out of pocket. Px12. Respondent shall pay directly to Petitioner the remaining balance of **$2,307.00** to Petitioner pursuant to Sections 8(a) and 8.2, and shall reimburse Petitioner **$65.00** for out of pocket monies spent. 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.

Regarding Hinsdale Surgical Center bill, Petitioner incurred $4,882.00 in charges for which $2,196.60 was written off, $1,529.57 was paid by Petitioner's Humana group health plan and for which Petitioner paid $500.00 out of pocket. Px13. Therefore, the balance is zero. Respondent shall reimburse Petitioner **$500.00** for out of pocket monies spent. 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.

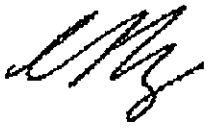
ISSUE (L) ***What Temporary Benefits Are in Dispute?***

Petitioner testified he was unable to work for Respondent for seven weeks, from 2/9/15 through 3/30/15. *See also*, Ax1. Although Petitioner testified that he was unable to work, the Arbitrator declines to award temporary total disability benefits for the time period sought. Ax1. In order to be eligible for such disability benefits, Petitioner must not only show that he did not work but also that he could not work. Here, Petitioner has only proven that he did not work by his own choice. There is no evidence that he could not work due to a doctor's order. Therefore, the Arbitrator ***denies*** payment of temporary total disability for the time period specified herein. Ax1.

ISSUE (K) ***Is Petitioner entitled to any prospective medical care?***
ISSUE (O) ***Future Medical Treatment***

Having found in favor of Petitioner on the issues of accident and causation, the Arbitrator concludes that the preponderance of the evidence showed Petitioner's condition of ill-being has not yet stabilized and that he is still in need of further medical care to treat, cure and/or otherwise relieve his condition of ill-being. Dr. Espinosa opined that due to Petitioner's condition, he may benefit from a trial of epidural steroid injections as Petitioner did not want to try surgery as the most definitive means of treating his condition. Petitioner testified and medical records show that Petitioner underwent one epidural steroid injection treatment with Dr. Glaser at L4-5 and L5-S1. Petitioner credibly testified that the injection brought temporary relief and that he continues to experience back and leg pain. petitioner has not completed the trial injections recommended by Dr. Espinosa due to out of pocket costs.

Based on the foregoing, the Respondent shall pay for and authorize for the lumbar epidural steroid injections recommended by Dr. Espinosa, along with all incidental medical care thereto.



Signature of Arbitrator

11-12-15
Date

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

Chandra Jackson,
Petitioner,
vs.

NO: 14 WC 34183

16IWCC0414

USA Technologies Inc.
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 18, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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.

JUN 17 2016

DATED:
o060916
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JACKSON, CHANDRA
Employee/Petitioner

Case# **14WC034183**

16IWCC0414

USA TECHNOLOGIES INC
Employer/Respondent

On 11/18/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2194 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

1296 CHILTON YAMBERT PORTER LLP
MEGAN A REID
303 W MADISON ST SUITE 2300
CHICAGO, IL 60606

16IWCC0414

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

Chandra Jackson
Employee/Petitioner

v.

USA Technologies Inc.
Employer/Respondent

Case # **14** WC **34183**

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 **Peoria, Illinois**, on **September 23, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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] What temporary benefits are in dispute?
   [ ] TPD [ ] 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. [ ] Is Respondent due any credit?
O. [x] Other **Motion to Bar/Due Process**

FINDINGS

On **or about June 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 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 $**13,191.30**; the average weekly wage was $**286.77**.

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 $**0** under Section 8(j) of the Act.

ORDER

Having found that Petitioner failed to provide that she sustained a repetitive trauma injury on or about June 25, 2014, Petitioner's 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

11/16/15
Date

NOV 18 2015

Attachment to Arbitrator Decision
(14 WC 34183)

FINDINGS OF FACT:

Petitioner, Chandra Jackson, was employed by Respondent, USA Technologies, Inc., on or about June 25, 2014. Respondent fabricates car parts for automobile manufacturers. Petitioner worked for Respondent as parts cleaner and a machine operator.

Petitioner testified that she began her employment with USA Technologies in August 2013 as a parts cleaner. Petitioner stated that she used both hands as a parts cleaner. She took parts off a shelf, set same on the floor and use a putty knife to remove splatter (slag) from welding parts. Petitioner also indicated that part of the process required that she turn, grind and chip the parts with her hands.

Petitioner testified that she later applied for and received the position of a machine operator. As a machine operator, she stood on a pallet, pulled parts and cleaned them. She took off and cleaned drill bits while simultaneously pulling parts from another machine. Petitioner provided that the process required gripping and the use of vibratory tools.

Petitioner offered into evidence a "Petitioner's Job Description Form" which she prepared on October 23, 2014. (PX3) The form provides that a putty knife was the "type of tools or equipment used." Petitioner described the machine used as, "Putting parts in machine, taking them out, grabbing for other parts, consistently do the same thing." Petitioner wrote that "From Aug 2013 to June 2014, use putty knife to clean parts; [eligible] to present, place parts in cleaning machine." When asked to describe any aspect of your work station that you feel caused you to experience an increase in symptoms, Petitioner wrote, "Well when I was cleaning constantly turning the part plus cleaning the part w/the knife." She further described, "On machine constantly grabbing parts, putting them in machine." When asked to describe her body posture while working at her station, she wrote, "Standing, arms and hands in front of me, at midline."

Petitioner testified that she began to notice numbness in her hands in March 2014. She notified her employer that she believed she had sustained a repetitive trauma injury to her hands on or about June 25, 2014. A "Supervisor's Accident Investigation" report dated June 23, 2014 show Petitioner reported pain and numbness in her bilateral arms and wrists due to repetitive motion on that date. The Accident Report documents that Petitioner's symptoms appeared to have been present for 3-4 months and she requested an appointment with the "company doctor." (PX 2)

Petitioner presented to OSF Saint Francis Medical Center in Peoria on June 25, 2014 where she began treating with Dr. David Braun. Petitioner provided that she had been a parts cleaner for nine month until five weeks prior when she began working as a machine operator. She reported the job involved gripping and twisting with both hands. Petitioner informed the doctor that approximately three months prior she began to notice pain in bilateral distal flexor forearm/wrists. She also reported bilateral numbness in the bilateral hands in the palmar and extensor side from the wrist down over the past three weeks. After performing an examination, Dr. Braun assessed bilateral wrist pain and bilateral hand paresthesias. Dr. Braun described Petitioner's bilateral

hand paresthesias as non-anatomic. The doctor issued Petitioner a cock-up splint to wear on both wrists at night and gave her modified-duty work restrictions. (PX 4)

Petitioner returned to Dr. Braun for follow-up on July 10, 2014. She reported paresthesias over various places of her hands bilaterally. Dr. Braun assessed bilateral wrist pain and hand paresthesias, unknown etiology. Dr. Braun felt that "the pattern of paresthesias that she describes is not specific to any certain dermatome." He ordered an EMG to rule out carpal tunnel syndrome. (PX 4) Petitioner underwent the EMG at Illinois Neurological Institute PM&R on August 13, 2014. The studies showed moderate right median neuropathy and mild left median neuropathy. (PX6)

On August 20, 2014, Petitioner returned to Dr. Braun. Petitioner informed the doctor she was working modified duty with no change in her symptoms. She also had quit smoking two weeks earlier. She described paresthesias in all five fingers on the flexor and extensor sides of her bilateral hands, fingers, and palms. Dr. Braun indicated he was unsure of the etiology, as Petitioner's reported symptoms covered multiple dermatomes. According to Dr. Braun, "it is more of a stocking/glove type distribution which is why I did a hemoglobin A1C today, which was normal. I am going to obtain a CRP and a TSH to look for non-entrapment causes of her symptoms." (PX5)

On August 21, 2014, Dr. Braun authored a "Notification Letter" addressed to Petitioner. In the notification, Dr. Braun informed Petitioner that her C-Reactive Protein levels (1.19) were outside of the normal values. He advised Petitioner that "an elevated C-Reactive Protein may represent a medical/inflammatory cause of your wrist pain; please follow-up with your primary care provider for further evaluation." (PX 5)

Records submitted show Petitioner saw her primary care physician, Dr. Norman Nathan, on September 22, 2014. Dr. Nathan recorded that he discussed the lab results with Petitioner. Dr. Nathan noted the results showed a normal TSH and a mildly elevated C-Reactive Protein. The doctor indicated that he informed Petitioner that the "[C-Reactive Protein indicator] is a non-specific inflammatory indicator and it is probably related to her chronic back issues and shoulder pain." Prior medical records from Dr. Norman Nathan confirmed Petitioner had treated for chronic back pain, shoulder pain, and right and left leg numbness in the past several years. (RX 7)

Petitioner returned to Dr. Braun on September 30, 2014. Petitioner reported that her symptoms were unchanged. Dr. Braun reviewed the EMG studies and lab work, which showed elevated C-Reactive Protein levels. Dr. Braun indicated Petitioner reported to him that she had discussed the elevated CRP levels with her primary care physician, Dr. Norman Nathan. Dr. Braun stated "I am unsure of the etiology of her rather pronounced symptom of hand pain and wrist pain bilaterally. Her paresthesias continues to be non-anatomic and involve more than one nerve distribution." The doctor indicated that he was requesting the records from Petitioner's visit with Dr. Nathan to see why he felt Petitioner's elevated CRP was not an explanation for her serve pain bilaterally. The doctor further issued a referral to Dr. Anane-Sefah as he felt Petitioner had moderate median neuropathy of the right wrist per the EMG. (PX 4)

Petitioner subsequently came under the care and treatment of Dr. Blair Rhode who ultimately performed a right carpal tunnel release on November 18, 2014 and a left carpal tunnel release on January 6, 2015.

Dr. Rhode testified pursuant to evidence deposition. He testified that Petitioner presented to him on October 8, 2014, for examination and reported a history of hand pain and numbness that began on March 25,

2014. She reported an onset while working as a machine operator. Her job required Petitioner to manipulate parts, reach and pull parts weighing 10-20 pounds. She also cleaned parts with putty knife and cleaned splatter from welds. (PX 12, pp. 7-8) Dr. Rhode testified that during examination, Petitioner demonstrated bilateral positive Tinel's and Phalen's maneuvers. He indicated same was consistent with the August 13, 2014 EMG findings. (PX 12, p.16) The doctor stated that in addition to examination, he also performed ultrasounds of the right and left wrists which he opined were considered positive for carpal tunnel. (PX 12, p.17) Dr. Rhode testified that he also performed a steroid injection in the right wrist which provided temporary relief. Dr. Rhode provided that after failed attempts at conservative care, he discussed surgery with Petitioner. The doctor provided that "she was unwilling to live with her symptoms and wished to proceed with surgical intervention..." (PX 12, p.20) Dr. Blair Rhode performed a right carpal tunnel release on November 18, 2014 and a left carpal tunnel release on January 6, 2015. Dr. Rhode testified that during his assessment he felt that a causal relationship existed between Petitioner's bilateral carpal tunnel syndrome and her activities at work. Dr. Rhode stated, "It was my opinion that the patient had sustained a work related injury secondary to her exposure as a machine operator. I further went on to talk about specific activities including parts. The cleaning motion that the patient described was holding the part with one hand while cleaning with a puddy knife with the other and, again, cleaning splatter from welds..." (PX 12, pp.17-18) Dr. Rhode further testified that he was not aware of any medical literature supporting a direct relationship between bilateral carpal tunnel syndrome and Lupus. (PX 12, p.12) On cross-examination, the doctor testified that from a medical standpoint, there would have been no harm to Petitioner had she waited additional time to schedule the surgeries. He also stated that lupus or anti-inflammatory diseases do not typically present with numbness or tingling in the wrist or hands. (PX 12, p.38)

At Respondent's request, Petitioner presented for an independent medical examination with Dr. Kevin Walsh at DuPage Medical Group on January 8, 2015.

At the time Petitioner presented for the IME with Dr. Walsh, Petitioner had already undergone carpal tunnel release surgeries on both hands. Petitioner provided a history to Dr. Walsh of numbness in all five digits of her hands, beginning in March 2014; she related the symptoms to work activities of cleaning with a putty knife. Petitioner specifically denied using vibratory tools, a mallet, a hammer, or repetitive loading activities at work. (RX 5, RX 6)

At his evidence deposition, Dr. Walsh testified that you can't have numbness in all five digits as a result of carpal tunnel syndrome. Dr. Walsh explained that "Carpal tunnel syndrome effects the median nerve, and half the ring finger. It does not enervate the fifth digit at all." Dr. Walsh felt there was no evidence to suggest Petitioner sustained any repetitive trauma injury to her bilateral wrists. He provided that that using a putty knife is not traumatic. The doctor noted that Petitioner provided that she was not using any vibratory tools, a mallet, a hammer, or repetitive loading activities to her hands that were strenuous. (RX 5, pp.8-10, 23)

Dr. Walsh testified that he reviewed Petitioner's blood work from OSF Hospital, which suggested an elevated CRP level. Dr. Walsh explained that an elevated CRP level indicates the patient has an inflammatory state going on. The doctor provided that "...you would worry about an inflammatory disease such as lupus or other arthropathies, inflammatory arthropathies. "(RX 5, p.16)

Dr. Walsh testified that during his physical examination, Petitioner still reported ongoing numbness in all five digits of her right hand. Dr. Walsh reiterated that the median nerve effects only the thumb, index, long and half of the ring digit. He stated, "You can't explain numbness of the fifth digit based on that diagnosis [carpal

tunnelsyndrome]. Certainly the fact that the numbness had not resolved calls into question whether the surgery really fixed her condition. She may have had something else going on besides carpal tunnel syndrome to account for her numbness." (RX 5, p.21)

Dr. Walsh opined that there was no evidence that Petitioner had sustained a repetitive trauma injury to her bilateral hands. He testified that working with a putty knife was not the type of repetitive, strenuous activity that could lead to carpal tunnel syndrome. (RX 5, pp.23-24)

With respect to the elevated CRP level, Dr. Walsh testified that there was no clear explanation in the medical records for the elevated CRP level. He indicated it's a sign of an underlying inflammatory disease process. He stated that he did not find any outward signs on physical examination of lupus but the elevated CRP could not be explained on the basis of a diagnosis of carpal tunnel syndrome. (RX 5, pp.25-26)

On cross-examination, Dr. Walsh was questioned regarding Petitioner's reported temporary relief from the injection administered by Dr. Rhode. Dr. Walsh testified, "I have a little bit of trouble with that because if you look at Dr. Rhode's note, he actually injected the wrist joint...He didn't inject her carpal tunnel. If you're going to say she had temporary relief following the injection, the injection has to be in the carpal tunnel, not into the wrist joint. So the fact she got temporary relief following an injection in the wrist joint doesn't support the diagnosis of carpal tunnel syndrome at all." (RX 5, p.45) Dr. Walsh added "...her symptoms don't match the diagnosis of carpal tunnel. There's a conflict between the findings of Dr. Braun which is the numbness in all five digits, the findings of Dr. Rhode which say it's only three digits, and history she gave me that she had it in all five digits. There's a conflict in her symptoms." (RX 5, p.46)

At trial, Petitioner testified that Dr. Nathan had ordered additional blood work, but she was not certain of the results. She was unsure of where or when the additional blood work was ordered. She was unsure of the name or location of the doctor who took additional blood work or any other referrals pertaining to additional blood work. Petitioner also denied any prior treatment to her right or left hand, or any other treatment to her right or left arm. She denied any prior injuries or treatment to her right or left shoulder. She denied any prior treatment or injuries to her neck. She denied any prior history of numbness or tingling in her arms or legs. She did recall prior numbness in her feet. She did recall a prior history of low back pain for several years. She denied any other injuries after June 25, 2014.

A review of medical records submitted at trial indicates that Petitioner did have prior reports of numbness in her legs, as well as her arms prior to June 25, 2014. Medical records from Methodist Hospital emergency room show she was admitted for swollen joints in January 2007. (RX 8) She was diagnosed with a left hand/arm veinous thrombosis. She treated for an injury to her left knee in February 2004, and reported symptoms of peripheral neuropathy in her feet and legs in 2004. She had also treated for an onset of shoulder pain in 1999 after wrestling with a friend.

Medical records from OSF Hospital in April 2014, documented a history of leg pain and numbness after a fall. Petitioner provided a history on that date of pain in her right thigh that radiated to her toes. The pain began a month and half earlier. Her legs reportedly had given-out due to weakness. The pain was described to the emergency room personnel as radicular in nature.

At trial, Petitioner was questioned about a reported fall at home in October 2014. An absence report was submitted into evidence that documented a report of an injury when Petitioner "fell down front stairs at home on October 3, 2014." (RX 14) Petitioner denied any fall at home, and denied ever being on crutches at that time.

A second absence report dated November 1, 2014, was submitted into evidence, documenting that Petitioner had been hospitalized. (RX 15). Petitioner testified she did not recall, but may have been hospitalized for back pain. Medical records submitted into evidence from OSF Hospital state that Petitioner was admitted to the emergency room on November 2, 2014, for pain that was off and on over the past year. (RX 9) The pain had worsened over the last two weeks. The records state Petitioner presented with symptoms of cough, shortness of breath, chest pain, and abdominal pain. There is no mention of low back pain. She reported a history of prior blood clot in her left arm several years earlier.

With respect to (C.) Did an accident occur that arose out of an in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that she sustained a repetitive trauma injury on or about June 25, 2014. In doing so, the Arbitrator finds the opinions of Dr. Walsh to be more persuasive than those of Dr. Rhode. Dr. Rhode testified he did not obtain or review any of Petitioner's prior medical records. Dr. Walsh testified that repetitive trauma injuries require both repetition and strenuous activity. He testified that cleaning parts with a putty knife is not the type of repetitive, strenuous activity that would cause carpal tunnel symptoms. Dr. Walsh and Dr. Braun's records documented that Petitioner reported with symptoms involving all five digits of her bilateral hands, which represented a non-anatomic presentation that would not support a diagnosis of carpal tunnel syndrome. The Arbitrator finds the testimony of Dr. Walsh to be more persuasive and specifically relies on the opinions of Dr. Walsh in finding that Petitioner failed to prove by a preponderance of the evidence that she sustained a repetitive trauma injury to her bilaterally hands on or about June 25, 2014.

Moreover, the Arbitrator finds Petitioner's testimony less than candid. Petitioner's specific denial of prior medical treatment and injuries was contradicted by the medical records produced at trial. Her report of subjective complaints to Dr. Rhode was inconsistent with the subjective complaints documented in the medical records from Dr. Braun and Dr. Walsh. Petitioner was unable to testify as to the reason for her absence from work in October 2014 and November 2014, prior to electing to undergo a right carpal tunnel release with Dr. Rhode on November 18, 2014. The Arbitrator would expect Petitioner to recall the basis for her medical leave, especially where it required hospitalization.

Having found that Petitioner failed to prove she sustained a compensable accident, her claim for compensation is denied. With exception to issue (O.), all other issues are rendered moot.

With respect to O. Should Respondent's Motion to Bar the Opinions of Dr. Rhode be granted, the Arbitrator finds as follows:

Respondent has filed a Motion to Bar the Opinions of Dr. Rhode due to Petitioner's election to proceed with right and left carpal tunnel release surgeries before examination by its IME physician, Dr. Walsh. Prior to the IME, a letter was sent on November 14, 2014, by Respondent's counsel to the attorney for Petitioner, requesting "that Petitioner wait to proceed with any surgical treatment until we have an opportunity to have her examined by an IME physician." (RX 3) Respondent asserts that Petitioner's election to proceed with surgery

before the IME examination compromised its opportunity to independently evaluate the need for surgery and, thus, to defend the case.

The Arbitrator finds that there is no provision in the Act that provides a Section 12 examination is required before treatment commences. Petitioner's desire to undergo the prescribed treatment is not contingent on a Section 12 examination. As noted in Section 8(a) of the Act, "At any time the employee may obtain any medical treatment he desires at his own expenses." Respondent in this case exercised their Section 12 right when they obtained the examination of Dr. Walsh, albeit post-surgery, who by the way the Arbitrator relied on in rendering the decision. The Arbitrator denies said Motion to Bar and furthermore specifically finds that Respondent has been given due process in this case.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Louis Rufin,

Petitioner,

vs. NO: 15 WC 16516

16IWCC0415

Get Fresh Produce Inc.

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, prospective medical 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, 2015, is hereby affirmed and adopted.

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

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

16IWCC0415

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: JUN 17 2016
o051916
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

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

RUFIN, LOUIS
Employee/Petitioner

Case# **15WC016516**

16IWCC0415

GET FRESH PRODUCE INC
Employer/Respondent

On 11/6/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0700 GREGORIO & ASSOC
TODD P KLEIN
2 N LASALLE ST SUITE 1650
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
TIMOTHY S McNALLY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

16IWCC0415

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)

Louis Rufin
Employee/Petitioner

v.

Get Fresh Produce, Inc.
Employer/Respondent

Case # **15 WC 16516**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on September 28, 2015 and October 28, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **4/3/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $3,572.46; the average weekly wage was $892.86.

On the date of accident, Petitioner was 45 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 $1,479.74 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,479.74 .

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

ORDER

The Arbitrator finds that Petitioner failed to establish accidental injuries causally related to his employment. The Arbitrator adopts the opinions of Dr. Witkowski and Dr. Vora in finding that petitioner failed to establish an entitlement to benefits by a preponderance of the evidence.

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

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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, 2015
Date

ICArbDec19(b)

NOV - 6 2015

Petitioner is a delivery driver for respondent. He delivers produce to local restaurants. Petitioner testified that he unloads a truck with boxes of produce by pushing a two-wheel dolly down a ramp. Petitioner described the ramp as being at a 45-degree angle.

Petitioner testified that he experienced a work accident on April 3, 2015. That morning, he picked up his truck in Bartlett, Illinois to drive to Chicago to make a delivery to Weber Grill in the River North neighborhood. Petitioner arrived at Weber Grill to deliver produce, and testified that he made approximately three to four trips inside. As petitioner was unloading boxes of potatoes, which he approximated weighed between 200 and 220 pounds, he felt a crunching, pinching and stabbing sensation in his right foot. Petitioner testified that this occurred as he was walking halfway down the 45-degree ramp while holding the dolly.

Petitioner testified that he felt immediate pain, but was able to finish his workday. Per petitioner's testimony, he finished his route in extreme pain, but felt some improvement over the weekend while wearing gym shoes.

Petitioner first sought medical care at Cadence Occupational Health Clinic on April 6, 2015. (Petitioner's Exhibit 1). Upon reporting to that facility, the history was noted that petitioner had "felt a crunch, pinch in the area of the metatarsal phalangeal articulation," while "walking with products down a ramp on a two-wheeler." X-rays were negative for fracture or dislocation, and an examination revealed no soft tissue swelling.

Petitioner noted that "the pain worsens only when he is wearing his Red Wing work boots which he started wearing about 3 weeks ago. Was able to wear his gym shoes over the weekend and walked to the park without problems. However, when he put his work boots back on today for work, his pain increased." Following an evaluation, Dr. Baksinski instructed petitioner to take ibuprofen and released him to regular work. The diagnosis was right foot pain. (Petitioner's Exhibit 1).

Petitioner returned to Dr. Baksinski on April 8, 2015. (Petitioner's Exhibit 1). He complained of pain localized in the right foot, apparently between the second and third metatarsals. Petitioner described the pain as moderate and intermittent. Petitioner again noted that the pain was worsened by work boots, and described the sensation to feeling "like he's walking on a rock." Petitioner noted that he had purchased Dr. Scholl's inserts, without improvement. Petitioner noted that he initially felt well at home, but that his foot had been aggravated to the point of "excruciating pain" when he needed to walk 7 to 8 minutes from the employer's parking lot to work. (Petitioner's Exhibit 1).

A physical examination appears to have been normal, and Dr. Baksinski noted the possibility of a neuroma. Work restrictions were provided at this time, and included no use of pedals to drive and no ramp work. (Petitioner's Exhibit 1).

Petitioner returned to Dr. Baksinski on April 20, 2015. (Petitioner's Exhibit 1). Petitioner reported no improvement, and pain as a 7 on a scale of 10. Petitioner also reported numbness in his right foot, and "pain that

radiates up the right leg to the upper thigh." Dr. Baksinski noted that the radiology reports had been negative. He prescribed Naproxen and continuing work restrictions. Petitioner also received a referral to a podiatrist. (Petitioner's Exhibit 1).

Petitioner reported to Dr. Witkowski with the orthopedics division of Cadence Physician's Group on April 22, 2015. (Petitioner's Exhibit 2). Dr. Witkowski noted that petitioner had been referred by Dr. Baksinski. Petitioner reported that he had been working on restrictions, which included sitting at a high stool. Petitioner reported to Dr. Witkowski that, since the accident, "he has noticed pain located on the medial aspect of his foot, which radiates all the way up into the medial aspect of his leg and into the groin area." Petitioner rated the pain as an 8 on a scale of 10, and was not complaining of any back pain. Dr. Witkowski stated the following:

> I had a long discussion with him regarding his current condition. I cannot attribute any organic problem with his foot that is leading to the radiating pain of the medial aspect of the leg. He had no specific injury at work and I am finding it very hard to agree with this being a work comp incident. He may have developed metatarsalgia. I discussed with him that metatarsalgia would not cause radiating pain up the leg. Other potential etiology of his symptoms could be his lumbar spine or some type of radicular pain. However, I would like to get an MRI of the foot to rule out any organic problem with the foot...
>
> (Petitioner's Exhibit 2).

Petitioner opted not to return to Dr. Witkowski or Dr. Baksinski. Rather, he established care with Dr. Betman, a podiatrist. (Petitioner's Exhibit 3). After petitioner began care with Betman, respondent requested a Section 12 evaluation with Dr. Vora of the Illinois Bone and Joint Institute. Dr. Vora evaluated petitioner on May 29, 2015. Prior to trial, both Dr. Betman and Dr. Vora offered their testimony via evidence deposition.

TESTIMONY OF DR. BETMAN

Dr. Betman testified that he first evaluated petitioner on April 25, 2015. At that time, petitioner provided a history that he had been descending a ramp while on a truck when he felt something inside his foot. Petitioner denied any trauma. (Petitioner's Exhibit 4 at 11). Dr. Betman conducted an evaluation, which included X-rays and ultrasound. The X-rays were negative for fracture and Dr. Betman was of the opinion that the ultrasound was positive for a neuroma of the third interspace. Dr. Betman testified that a neuroma is a thickening or swelling of a nerve. (Petitioner's Exhibit 4 at 11-13).

Dr. Betman believed that the condition was related to the alleged work accident. As a basis for this opinion, Dr. Betman described that he believed that petitioner had suffered a "squeezing, a compression-type injury, that he sustained obviously some type of trauma while walking down the ramp." (Petitioner's Exhibit 4 at 14).

Dr. Betman prescribed Tramadol and recommended physical therapy. He also placed petitioner off of work at that time. (Petitioner's Exhibit 4 at 14-15). Petitioner returned to Dr. Betman on May 11, 2015 at which time he reported little improvement. As such, Dr. Betman recommended an injection and compounding cream in addition to therapy. (Petitioner's Exhibit 4 at 15-16). As to work restrictions, Dr. Betman believed that petitioner could work a mainly sedentary job. (Petitioner's Exhibit 4 at 17). At this time, Dr. Betman also recommended custom orthotics to treat petitioner's symptoms. (Petitioner's Exhibit 4 at 17-18).

Petitioner next reported to Dr. Betman on May 28, 2015. He continued to complain of significant pain at the third interspace in the foot, within an inability to walk more than one-half of one block before feeling symptoms. (Petitioner's Exhibit 4 at 19). As a result of those symptoms, it appears that Dr. Betman was of the opinion that petitioner could not work in any capacity. Dr. Betman continued to diagnose a neuroma, and recommended the petitioner seek hydrotherapy while he waited approval of the other services, i.e., the compounding cream, injection and therapy. (Petitioner's Exhibit 4 at 20-22). Dr. Betman also recommended Voltaren gel. (Petitioner's Exhibit 4 at 22).

Petitioner continued to report to Dr. Betman through June and July 2015. During that time, his complaints remained largely unchanged. Dr. Betman continued to recommend physical therapy, an injection, compounding cream and Voltaren gel. Dr. Betman also continued petitioner off of work. (Petitioner's Exhibit 4 at 23- 29).

Dr. Betman testified that he had reviewed the May 29, 2015 report of Dr. Vora. Dr. Betman testified that he disagreed with Dr. Vora's report. (Petitioner's Exhibit 4 at 29-30). The basis of Dr. Betman's opinion appears to have been that petitioner did not complain of pain prior to the reported work incident. Dr. Betman also believed that the ultrasound findings were consistent with petitioner's claimed injury. (Petitioner's Exhibit 4 at 30).

On cross-examination, Dr. Betman confirmed that petitioner denied any trauma occurred on the alleged date of accident. Specifically, petitioner denied hitting his foot, twisting his foot or stepping on an object. (Petitioner's Exhibit 4 at 32). Dr. Betman confirmed that the only history petitioner reported was that he was "going down the ramp of his truck and felt something." (Petitioner's Exhibit 4 at 34). Dr. Betman noted that he had not reviewed the records of Cadence Occupational Health or Cadence Orthopedics. (Petitioner's Exhibit 4 at 35-36). Dr. Betman also noted that a neuroma, which was his working diagnosis, would not cause pain to travel up into the ankle or the leg. (Petitioner's Exhibit 4 at 36-37). Dr. Betman later testified in response to questions regarding the mechanism of the accident and its causal connection to a neuroma, "well, again he felt something on the inside of his foot while he was – whatever caused it I don't know."

TESTIMONY OF DR. VORA

Dr. Vora, a board certified orthopedic surgeon, evaluated petitioner pursuant to Section 12 on May 29, 2015. (Respondent's Exhibit 1 at 4-8).

Dr. Vora took a history from petitioner, who reported that he experienced a sudden onset of right foot pain while walking down a ramp with a two-wheel dolly. (Respondent's Exhibit 1 at 8). Petitioner reported that he believed that the pain may be caused by his work boots, so attempted to loosen the same and continue work. (Respondent's Exhibit 1 at 8). Dr. Vora reviewed medical documentation and conducted a physical examination. Following the same, he diagnosed subjective right foot pain. (Respondent's Exhibit 1 at 8-10).

Dr. Vora specifically noted that petitioner's pain pattern was non-anatomical, noting that petitioner's complaints of pain radiating up towards the groin could not be explained by a neuroma. (Respondent's Exhibit 1 at 10-11). Dr. Vora was of the opinion that there was no objective evidence of a foot injury. (Respondent's Exhibit 1 at 11). Dr. Vora testified that he would disagree with the diagnosis of a neuroma for several reasons. First, Dr. Vora noted that "I have never had a single patient complain of pain from a neuroma that goes to the knee and into the groin. There is no literature that would ever document that or support that. It's anatomically impossible. It doesn't work that way." (Respondent's Exhibit 1 at 11-12). Moreover, Dr. Vora explained that neuromas do not occur as a result of an incident as described by petitioner. Dr. Vora explained that an interdigital Morton's neuroma "cannot occur from a misstep." (Respondent's Exhibit 1 at 12).

Dr. Vora testified that he did not believe that ultrasound was of diagnostic benefit in evaluating neuroma. Dr. Vora noted that for an ultrasound to have any value, it must correlate with the clinical findings.

(Respondent's Exhibit 1 at 13). Dr. Vora described the ultrasound as a subjective test, and that clinical examination did not support the notion that petitioner suffered from a neuroma. (Respondent's Exhibit 1 at 13-15). Dr. Vora reiterated that the records of Dr. Witkowski also did not support that diagnosis, nor did the alleged mechanism of accident.

Dr. Vora further explained his belief that the mechanism of accident could not have caused a neuroma. (Respondent's Exhibit 1 at 15). Dr. Vora explained:

> So a neuroma is a soft tissue condition. It's a nerve that's like a piece of spaghetti. If you had an incident for example that causes somebody to have a trauma or a misstep, to injure the nerve would be like – it's simply impossible to injure the nerve which is a soft piece of spaghetti before example you can get a fracture of the metatarsal which surrounds the tunnel. So people can have a misstep, have a hyper plantar flexion or dorsal flexion injury and get a metatarsal stress fracture or a metatarsal fracture or a Lis franc injury which is ligaments in the midfoot that go first, but those are static structures that are rigid. You don't just get a piece of spaghetti looking neuroma all of a sudden becoming inflamed from a misstep. There is no – you can review 1,000 orthopedic journal articles on the causation of neuroma and you wouldn't see that description as an etiology. It doesn't make sense.

(Respondent's Exhibit 1 at 13-14).

Dr. Vora explained that even if petitioner's mechanism of accident is accepted as true, a neuroma could not be caused. (Respondent's Exhibit 1 at 38). Dr. Vora noted that a bone injury must be present to cause a stretching of the nerve. (Respondent's Exhibit 1 at 38-39). Conversely, non-traumatic neuromas, in the opinion of Dr. Vora, were conditions that are slowly aggravated. He noted that "it starts slowly, and then after a few months it starts getting worse and worse." (Respondent's Exhibit 1 at 39).

Dr. Vora reiterated that he did not believe that there was any objective evidence of an injury, and that there appeared to be no need for further care or work restrictions. (Respondent's Exhibit 1 at 16).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

As to issue "C," did an accident occur that arose out of and in the course of petitioner's employment by respondent, the arbitrator finds as follows:

The Arbitrator finds that petitioner failed to establish an accident arising out of or occurring in the course of the employment. As petitioner was unloading boxes of potatoes, which he approximated weighed between 200 and 220 pounds, he felt a crunching, pinching and stabbing sensation in his right foot. Petitioner testified that this occurred as he was walking halfway down the 45-degree ramp while holding the dolly.

The records of Dr. Betman confirm that petitioner solely reported feeling pain upon taking a step. He noted that petitioner reported that there was no trauma, denied twisting, denied hitting his foot on anything, and denied stepping on anything. (Petitioner's Exhibit 4 at 31-32). This lack of trauma is consistent with reports to Dr. Baksinski. It is further worth noting that Dr. Witkowski stated "He had no specific injury at work and I am finding it very hard to agree with this being a work comp incident." Dr. Vora classified the history as a "misstep."

While petitioner was moving a dolly down a ramp, there is a lack of evidence in the record to support that the dolly or ramp played any role in the alleged work accident. There is no evidence in the record to support that the ramp was defective or hazardous. Moreover, pushing a dolly, with nothing more, does not constitute a work accident. In essence, petitioner's testimony and history to the medical providers is that he felt pain while taking a step. In this regard, it is also worth noting that none of the medical providers attributed the alleged injury to the incline of a ramp or the weight of a dolly. In fact, when questioned on this point, Dr. Betman waffled:

Q: ... If Mr. Rufin testified that he was using a two-wheeler and he was walking heavy product down a ramp how would that cause a neuroma?

[objections and response omitted]

A: Well, again he felt something on the inside of his foot while he was - - Whatever caused it I don't know.

(Petitioner's Exhibit 4 at 41).

The Arbitrator notes that the "'arising out of' component of a compensable workers' compensation injury 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." *Sisbro v. Indus. Comm'n*, 207 Ill. 2d 193; 797 N.E.2d 665 (2003). Here, petitioner has failed to establish that his alleged injury resulted from anything other than taking a step and experiencing pain. "If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment. However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable." *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52; 541 N.E.2d 665 (1989). The Arbitrator finds that petitioner's testimony and history to the medical providers fails to support a hazard unique to his employment.

Therefore, the Arbitrator finds that petitioner failed to establish an accident arising out of his employment.

As to issue "F," is petitioner's current condition of ill-being causally related to the injury, the arbitrator finds as follows:

Even if petitioner had established an accident arising out of the employment, the arbitrator finds that petitioner failed to carry his burden of proof in establishing that his injuries are causally connected to the alleged accident. The arbitrator begins by noting that it is axiomatic that the petitioner carries the burden of proof to establish the issue of causal connection by a preponderance of the evidence. *Sisbro v. Indus. Comm'n*, 207 Ill. 2d 193; 797 N.E.2d 665 (2003). The arbitrator notes that the only two orthopedists who evaluated petitioner did not believe that petitioner had suffered a work injury. One of these physicians was Dr. Witkowski, a treating physician. Dr. Witkowski's opinions are bolstered by respondent's Section 12 examiner, Dr. Vora.

It is worth noting that Dr. Witkowski's records clearly state his belief that he did not believe petitioner had suffered a work accident. Dr. Witkowski noted that petitioner had "no specific injury at work and I am finding it very hard to agree with this being a work comp incident." (Petitioner's Exhibit 2) Petitioner ceased treatment with Dr. Witkowski after Dr. Witkowski offered this opinion.

The Arbitrator notes that Dr. Witkowski's assessment is consistent with the opinions of Dr. Vora that a "misstep" would be incapable of causing a neuroma. Dr. Vora noted that development of a neuroma from an incident as described by petitioner would be anatomically impossible, and that a traumatic neuroma would require a broken bone or other ligamentous injury.

Dr, Witkowski and Dr. Vora offered rather empatic opinions that the neuroma could not be related to work. While Dr. Betman opined to the contrary, the Arbitrator notes that he did not provide a detailed basis for his opinion. First, it must be noted that Dr. Betman did not review the records of Cadence or Dr. Witkowski. (Petitioner's Exhibit 4 at 36). While Dr. Betman testified that petitioner "sustained obviously some type of trauma while walking down the ramp," he failed to explain the nature of the trauma. (Petitioner's Exhibit 4 at 14). When questioned on this point, Dr. Betman appeared to be of the opinion that so long as petitioner experienced symptoms at work, then the case should be covered under workers' compensation. Dr. Betman stated "Well, again he felt something on the inside of his foot while he was - - Whatever caused it I don't know." (Petitioner's Exhibit 4 at 41). When evaluating all of the evidence, the Arbitrator finds that the opinions of Dr. Betman lack sufficient basis to overcome the opinions of Dr. Witkowski and Dr. Vora, the two orthopedic specialists involved in this matter.

Moreover, Dr. Witkowski and Dr. Vora were both consistent in their opinions that there would be no anatomical explanation for petitioner's

complaints of radiating pain up through his leg. The arbitrator notes that these radicular complaints were reported to Dr. Witkowski, Dr. Vora and Dr. Betman. Even Dr. Betman acknowledged that a neuroma would not typically cause symptoms into the ankle or leg. (Petitioner's Exhibit 4 at 37). There is substantial disagreement in the record as to whether petitioner even suffers from a neuroma, and whether his complaints are anatomically credible based on the opinions of Dr. Vora.

Based on the opinions of Dr. Witkowski and Dr. Vora, the Arbitrator finds that petitioner failed to carry his burden of proof in establishing the issue of causal connection.

As to issue "J," were the medical services that were provided to petitioner reasonable and necessary" the arbitrator finds as follows:

Based on petitioner's failure to carry his burden of proof on the issues of accident and causation, the arbitrator denies the claim for medical expenses in its entirety.

As to issue "K," is petitioner entitled to prospective medical care, the arbitrator finds as follows:

Due to petitioner's failure to carry his burden of proof on the issues of accident and causation, the arbitrator denies the request for prospective medical care.

As to issue "I," what temporary benefits are in dispute, the arbitrator finds as follows:

Due to petitioner's failure to carry his burden of proof on the issues of accident and causation, all claims for temporary total disability benefits are denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Serzynski,
Petitioner,
vs.

NO: 08 WC 10834

16IWCC0416

Barge Terminal Trucking, Inc.
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 18, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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.

JUN 17 2016

DATED:
O05192016
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SERZYNSKI, BRIAN
Employee/Petitioner

Case# **08WC010834**

BARGE TERMINAL TRUCKING INC
Employer/Respondent

16IWCC0416

On 11/18/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0123 COHN & COHN
ERWIN COHN
77 W WASHINGTON ST SUITE 1422
CHICAGO, IL 60602

0000 INMAN & FITZGIBBONS LTD
COLIN MILLS
201 W SPRINGFIELD AVE #1002
CHAMPAIGN, IL 61820

16IWCC0416

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Brian Serzynski
Employee/Petitioner

v.

Barge Terminal Trucking, Inc.
Employer/Respondent

Case # **08** WC **010834**

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 **Robert Falcioni**, Arbitrator of the Commission, in the city of **Waukegan**, on **July 21, 2015 & October 21, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 27, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $**49,409.88**; the average weekly wage was $**950.19**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **2** dependent children.

Respondent shall be given a credit of $**39,274.52** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**39,274.52**.

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

ORDER

BECAUSE PETITIONER DID NOT SUSTAIN AN ACCIDENT THAT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT, BENEFITS ARE DENIED. ALL OTHER ISSUE ARE MOOT AND ARE NOT ADDRESSED HEREIN.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 13, 2015
Date

NOV 18 2015

STATE OF ILLINOIS)
) ss
COUNTY OF LAKE)

BEFORE THE WORKERS' COMPENSATION COMMISSION
OF THE STATE OF ILLINOIS

BRIAN SERZYNSKI,	)	
	)	
Petitioner,	)	
	)	No. 08 WC 010834
v.	)	
	)	Arbitrator Robert Falcioni
BARGE TERMINAL TRUCKING, INC.,	)	
	)	
Respondent.	)	

RIDER TO MEMORANDUM OF DECISION OF ARBITRATOR

I. STATEMENT OF FACTS

Hearing of this matter began on July 21, 2015, and was completed on October 21, 2015, before Arbitrator Robert Falcioni in Waukegan, Illinois. At hearing, the parties stipulated that BARGE TERMINAL TRUCKING, INC., hereinafter referred to as Respondent, was operating under the Illinois Workers' Compensation Act on December 27, 2007, the amended alleged date of accident (Petitioner's oral motion to amend the accident date from December 28, 2007 was granted by the Arbitrator). The parties further stipulated that BRIAN SERZYNSKI, hereinafter referred to as Petitioner, was employed by Respondent on December 27, 2007, and had an average weekly wage of $950.19.

Otherwise, the following issues are in dispute: (1.) accident/date of accident, (2.) medical causal connection, (3.) Petitioner's entitlement to medical benefits, (4.) Petitioner's entitlement to temporary total disability benefits, (5.) the nature and extent of Petitioner's injuries, and (6.) penalties and attorneys' fees.

(i.) Petitioner's Medical History

2008

On January 7, 2008, Petitioner was seen at Vista Medical Center. On the "Initial Assessment Form," it was indicated that Petitioner's chief complaint was "leg pain (complete leg/no known injury)." (RX 7, p. 52). The "Brief Assessment" noted that Petitioner complained of "pain to right leg starting last Thursday [January 3, 2008]. Pain radiates from hip down to thigh, to front of shin. No known injury." (RX 7, p. 52).

It was reflected that Petitioner was able to ambulate independently, and could perform all activities of daily living without assistance. Petitioner was alert, oriented to person, place and time. Petitioner was able to move all four extremities equally with equal strength. Petitioner denied numbness and tingling. The record further reflected that "TRUCK DRIVER WITH RT LEG PAIN STARTED SINCE LAST THURSDAY [JANUARY 3, 3008], NOW RADIATES FROM HIP DOWN, NO INJURY." (emphasis not added). (RX 7, p. 57).

On the treatment note itself, it was indicated that the history was obtained from Petitioner, and that he reported the onset of symptoms was five days prior [January 3, 2008] and that said symptoms "came on gradually and became progressively worse." (RX 7, p. 54). Symptoms were present and located in the right leg. Petitioner **"denied any history of recent trauma."** (emphasis added). An examination of the abdomen was performed which was normal, and without organomegaly or palpable mass. Petitioner was given Demerol, Visteril, and Flexeril. Petitioner was diagnosed with a myofascial strain and discharged home after he reported that he felt "much better." There was no work restriction indicated in the records. (RX 7, p. 54-55).

On January 8, 2008, Petitioner was seen by Dr. Todd Paxton. Petitioner presented with right leg pain which started "last week." Petitioner reported some constant numbness and intermittent weakness with radiating pain. An abdomen exam was unremarkable. Petitioner **believed that it was from his work but that he did not have any specific injury or incident that precipitated his symptoms.** (emphasis added). An MRI was ordered by the doctor and Petitioner was to follow-up in one week. (PX 6/RX 6, p. 48a).

On January 10, 2008, Petitioner's wife called Dr. Paxton and indicated that Petitioner was in "too much pain" to wait for the MRI scheduled for January 15, 2008. Petitioner also requested medication as he could not lie flat due to severe pain. As such, Petitioner was provided Vicodin and Valium. (PX 6, RX 6).

On January 12, 2008, Petitioner underwent an MRI of the lumbar spine at Vista MRI Institute in Gurnee, Illinois. The MRI report was read to reveal moderate central canal stenosis at L3-4 due to a broad-based disc bulge and hypertrophy of the ligamentum flavum. There was also moderate left foraminal stenosis due to a disc bulge and hypertrophy of the facet joints. Multiple Schmorl's nodes at multiple levels as described above were noticed and broad-based disc bulge at other levels without significant central canal stenosis or neuroforaminal stenosis was noted. (PX 1).

On January 14, 2008, Dr. Paxton indicated Petitioner was to see Dr. Engelhard for consultation. (PX 6, RX 6).

On January 15, 2008, Petitioner called Dr. Paxton and requested a refill on the Valium and Vicodin and Ibuprofen prescriptions. The doctor approved the Ibuprofen prescription but wanted Petitioner to try the other prescriptions before prescribing Valium and Vicodin. (PX 6).

On January 24, 2008, Petitioner saw Dr. Herbert H. Engelhard, Associate Professor at the University of Illinois at Chicago. Petitioner complained of right leg pain, which he stated began on December 28, 2007(emphasis added) when he was doing a roofing job which involved moving heavy buckets. Petitioner felt the onset of severe right leg pain which had continued until the present time. Petitioner's past medical history was positive for removal of a cyst in the left elbow in terms of surgical procedures. Petitioner had no significant medical conditions and the only medication was Ibuprofen. The doctor personally reviewed the MRI of the lumbar spine which showed moderate central canal stenosis with a disc bulge and hypertrophic ligaments at L3-4. There were lesser disc bulges at other levels, including L4-5, and Petitioner had degenerative changes throughout. Petitioner was diagnosed with lumbar radiculopathy and the doctor opined that the findings on the MRI scan were not severe. The doctor issued a plan of conservative treatment, and had verbalized this to Petitioner. The doctor believed that Petitioner should be off work while his radiculopathy improved, and Petitioner was to follow-up. (RX 6).

On February 7, 2008, Petitioner called Dr. Paxton requesting a referral to Dr. Arber for a possible steroid injection, per Dr. Engelhard's recommendation. (RX 6).

On February 7, 2008, Petitioner returned to Dr. Engelhard with a chief complaint of leg pain. The doctor noted that in his first appointment he prescribed Petitioner Voltram and Neurontin. Petitioner continued to have leg pain but indicated that the medications were helping. Petitioner was again diagnosed with lumbar radiculopathy, and the doctor again reviewed the MRI scan which showed "some stenosis." The doctor indicated that surgery might be an option and discussed this with Petitioner. Petitioner was to continue his medications and consider physical therapy. Petitioner was to also call Dr. Paxton for a referral for an epidural steroid injection. The doctor also reviewed the nature of Petitioner's occupation which was that of a truck driver and he was currently not working. (PX 1/RX 6).

Petitioner completed a "Patient Intake Form" at the Center for Diagnosis and Treatment of Pain (Dr. Arber) on February 15, 2008, referred by Dr. Engelhard. Petitioner again indicated that he slipped on December **28**, 2007. (emphasis added)(PX 1).

On February 29, 2008, Petitioner underwent lumbar epidural steroid injections due to his diagnosed degenerative disease at L3-4 and L4-5, and right L3-4 and L4-5 radiculopathy. (PX 1).

On March 25, 2008, Petitioner underwent a second lumbar epidural steroid injection due to his diagnosed degenerative disease at L3-4 and L4-5, and right L3-4 and L4-5 radiculopathy. (PX 1).

On April 15, 2008, Petitioner underwent a right transforaminal epidural steroid injection at L4-5. Petitioner was diagnosed with degenerative disease at L3-4 and L4-5. Petitioner was also diagnosed with a right L3-4, L4-5 radiculopathy. (PX 1).

On May 15, 2008, Petitioner returned to Dr. Engelhard for a follow-up visit. It was noted that Petitioner's diagnosis and chief complaint was that of lumbar radiculopathy and leg pain. Though the leg pain was better since the injections, Petitioner still complained of back pain. His review of symptoms was also positive for abdominal pain and it was noted that Petitioner might have an abdominal hernia. The doctor again reviewed the MRI scan which showed some disc herniation. Petitioner was diagnosed with chronic low back pain and improved lumbar radiculopathy. The doctor indicated that Petitioner might be a surgical candidate if the radicular pain returned after the steroid injections and/or if the back pain was intractable to conservative measures. More importantly, for the abdominal pain, Petitioner was to call Dr. Paxton as he might need evaluation for a possible abdominal hernia. Petitioner had never had a colonoscopy and the doctor emphasized that the abdominal pain was a pressing medical issue. The doctor did not expect that the lumbar disc would cause him to be having abdominal pain; however, the abdominal conditions might be causing the back pain. (PX 5).

On May 15, 2008, Dr. Engelhard wrote to Dr. Paxton. It was noted that Petitioner was doing better with respect to the leg pain after the epidural steroid injection, though Petitioner still had back pain. Dr. Engelhard was concerned about abdominal pains and Petitioner might have an abdominal hernia by report. Dr. Engelhard indicated that Petitioner was to call Dr. Paxton for this condition, though he did not think that the abdominal pain was coming from the back. Otherwise, if the leg and back continued to bother Petitioner, Dr. Engelhard would continue seeing him. Petitioner had a herniated disc and might be a surgical candidate. (PX 5/RX 6).

On May 21, 2008, Petitioner saw Dr. Paxton with complaints of stomach pain. Petitioner reported that he saw the neurosurgeon and pain specialist since his last visit and he has had three epidural steroid injections, which he would not go through again. The injections helped the pain in the right leg but he still had back pain. The

doctor was to schedule a colonoscopy as Petitioner had some continued abdominal pains and some blood from the rectum. The doctor was to consider a CT scan and await evaluation from the surgeon and GI. (PX 6, RX 6).

On May 30, 2008, Petitioner was seen at the Scheer Surgical Center in Gurnee, Illinois for pain over the lower abdomen and right groin. It was noted that Petitioner was pulling a heavy bucket at work on December 28, 2007 (emphasis added) when he slipped and noticed pain in his back and numbness down the right lower extremity. Petitioner had been seen and evaluated and treated for bulging discs and steroid injections were done for treatment of the problem. Since January and February, Petitioner had also noticed some discomfort over the lower abdomen near the groin. Petitioner did have some exacerbation with pain and activity and he also noticed blood in his stool on and off for some time. After examination, Petitioner's abdominal pain was questionably related to an umbilical and right inguinal hernia, of which The doctor recommended repair. Petitioner was also to undergo a colonoscopy. (PX 8/RX 6).

A phone note from Dr. Engelhard dated June 2, 2008 indicated that Petitioner's abdominal pain was due to a hernia in the lower area and hernia by belly button. There was a handwritten note that Dr. Liesen would repair. (PX 5).

On June 3, 2008, Petitioner saw Dr. Paxton. Petitioner presented for a physical examination. The last exam was a DOT exam in January 2006. Petitioner was diagnosed with chronic back pain and herniated disc, inguinal hernia, paresthesias in the right leg, radicular pain in the right thigh. (PX 6, RX 6).

On June 4, 2008, Petitioner underwent a colonoscopy. There is no indication in the record, despite Petitioner's attorney's request for same, that said procedure was medically, causally related to any alleged work accident. (RX 6).

On June 12, 2008, Petitioner underwent a right inguinal hernia repair with mesh and an umbilical hernia repair with mesh for his diagnosed right inguinal hernia and umbilical hernia. (PX 7/PX 8).

On June 14, 2008, Dr. Engelhard wrote "To Whom It May Concern," and indicated that Petitioner's diagnosis of lumbar radiculopathy was sustained when he was injured at work in December 2007. The doctor went on to indicate that Petitioner was currently off work and he understood Petitioner's work duties were in the heavy duty category. Based on the examination, Petitioner would be unable to fulfill those duties and would be re-evaluated in approximately one month. (PX 5).

On June 16, 2008, Dr. Liesen wrote "To Whom It May Concern," and indicated that Petitioner was first seen on May 30, 2008. Petitioner presented with lower abdominal pain. Petitioner had an accident at work in "December of 2007" which "disabled him." Petitioner had not been able to return to work since that time. Upon examination on May 30, 2008, Petitioner was found to have both a right inguinal hernia and an umbilical hernia. The doctor performed a right inguinal hernia repair and an umbilical hernia repair on June 12, 2008. Petitioner would not be able to return to work any sooner than 5 weeks post operatively. Petitioner's umbilical and or inguinal hernia could most certainty be related to his accident in December of 2007 "or from lifting and pulling at work prior to that time." (PX 8).

On June 26, 2008, Petitioner returned to Scheer Surgical for follow-up. It was noted that Petitioner was recovering well from hernia surgery and he was to do no heavy lifting for another week and them may resume all activity as tolerated. (PX 8/RX 6).

On July 7, 2008, Petitioner returned to Dr. Paxton for follow-up on an elevated blood pressure and multiple medical problems. It was noted that since the last visit, Petitioner had a normal colonoscopy. It was also noted that Petitioner had some incisional pains from his hernia surgeries and still had back pain. Petitioner was to follow-up with Dr. Engelhard. (RX 6).

Petitioner saw Dr. Engelhard on July 17, 2008. Petitioner was diagnosed with lumbar radiculopathy and his chief complaint was back and leg pain. Petitioner had his abdominal hernia repaired and the abdominal symptoms were much better. However, he continued to have difficulty with his back and right leg including pain and numbness. On examination, Petitioner had a severely antalgic gait and was in distress. Petitioner was to participate in some gentle physical therapy directed at his back and gait, and was given a prescription for Darvocet to use instead of Vicodin. As it had been more than 6 months since the MRI was done, and the MRI back then only showed a bulging disc and one more pronounced herniation without nerve root effacement, the doctor believed they should have an MRI to search for an explanation as to why his leg pain was so severe. The doctor believed that the herniations had progressed based on his clinical presentation. If Petitioner dramatically improved with physical therapy, they could hold on the MRI scan. (PX 5/RX 6).

On July 17, 2008, Dr. Engelhard wrote to Dr. Paxton and indicated that Petitioner continued to have right leg pain although the MRI from January, while abnormal, really did not look at all bad. Petitioner was placed on a regimen of physical therapy and his Ambien was renewed as well as a new prescription for Darvocet was given instead of Vicodin. Petitioner was to obtain a follow-up MRI to see if, in fact, the lumbar disc herniation had progressed and he might be a surgical candidate. (PX 5/RX 6).

On July 30, 2008, Petitioner underwent an MRI of the lumbar spine at Gurnee Radiology Center. The MRI report was read to reveal multi-level disc annulus bulge and acquired central canal stenosis, most significant at L4-5 where there were additional findings of a superimposed right paracentral to right lateral asymmetric component to the disc bulge, moderate acquired central canal stenosis and degenerative disc disease. There was also a small right paracentral disc herniation at T12-L1, diffuse degenerative spondylitic change and mild degenerative disc disease at L3-4 and L5-S1. (PX 5, PX 7).

An Outpatient Neck and Back Evaluation for from Vista Medical Center East was completed on August 11, 2008. It was noted that Petitioner had lower back and right leg pain with a date of onset of December 28, 2007 (emphasis added). (PX 5, PX 7).

On August 13, 2008, Petitioner completed the "Vista Medical Center 20-3978521 Accident/Other Payor Statement," and noted an accident date of "**12/28/07**." (emphasis added). (PX 7).

On August 18, 2008, Petitioner returned to Dr. Engelhard for follow-up. Petitioner was diagnosed with lumbar radiculopathy, chronic low back pain. The doctor reviewed the recent MRI which showed spondylosis and impingement at L3-4 and L4-5, as well as a milder degree at other levels. Petitioner was also reporting that he was having neck stiffness in the legs. Petitioner had only had one week of physical therapy so far, and it was noted to be too early to know whether it was helping. The doctor indicated that surgery was certainly an option and the doctor recommended strongly that he consider it, due to the nature of the changes on his MRI scan. (PX 5/RX 6).

On August 29, 2008, Petitioner underwent an EMG of the lower extremities. The impression was significant "evidence of right L-5 dermatomal conduction delays was replicated. (PX 4).

On September 4, 2008, Petitioner saw Dr. Engelhard with complaints of severe right leg pain. Petitioner reported that his right leg had been bothering him more and more and that he also had some back pain. Petitioner indicated his left leg was fine. It was noted that he had a recent MRI showing disc herniations at L3-4 and L4-5. Petitioner was diagnosed with lumbar radiculopathy and lumbar disc herniation. It was noted that Petitioner failed at all attempts at conservative measures and wished to proceed with surgery. Petitioner would undergo a lumbar laminectomy/discectomy. (PX 5/RX 6).

On September 4, 2008, Dr. Engelhard wrote to Dr. Paxton and indicated that Petitioner had not been doing well despite conservative measures for back and leg pain. It was also noted that Petitioner recently had a SSEP testing, which was positive for a right L-5 radiculopathy. It was noted that Petitioner would like to proceed with surgery. (PX 5/RX 6).

On September 8, 2008, Petitioner saw Dr. Paxton for follow-up on elevated blood pressure and multiple medical problems, as well as a rash for three weeks. Petitioner noted that he was very anxious and felt he was having trouble concentrating and he was emotionally strained and stressed. Petitioner also noted difficulty dealing with not working emotionally and financially. Petitioner indicated he had been having physical therapy on his back and that it was hit or miss on whether it felt good or bad. Petitioner was to follow-up with Dr. Engelhard and physical therapy and return in one month. (PX 6, RX 6).

On October 2, 2008, Petitioner underwent a hemilaminectomy at L-4, right, with hemilaminotomy, right at L3-L5. Disc exploration and excision of free fragments at L3-4 and L4-5 on the right was also performed. Petitioner's post-operative diagnosis was right lumbar radiculopathy with disc herniations and foraminal stenosis at L3-4 and L4-5. On the intake form, an accident date of "12/28/07" was noted.9emphasis added) (PX 5/PX 7).

On October 20, 2008, Dr. Engelhard wrote to Dr. Paxton and indicated that Petitioner was doing well after his lumbar surgery. He was not taking Vicodin anymore and his leg has improved. (PX 5).

On October 27, 2008, Petitioner saw Dr. Paxton for follow-up of his back pain. Petitioner reported he was doing much better and that his leg symptoms had resolved. Petitioner still had back pain with stiffness that was overall better. Petitioner was to follow-up with Dr. Engelhard in two weeks and continue home therapy. Petitioner was to follow-up in two months. (PX 6, RX 6).

On October 28, 2008, Petitioner was discharged from physical therapy. It was noted that Petitioner attended 18 sessions with no cancellations and no no-shows. (PX 7).

On December 10, 2008, Petitioner underwent a Functional Capacity Evaluation at Vista Health System. A date of injury was noted as "**12/28/2007**."(emphasis added) Petitioner demonstrated abilities in the medium physical demand level with an infrequent lift of 50 pounds to waist height and 30 pounds to shelf height. Petitioner was able to carry 60 pounds at waist level and was able to reach to all levels, climb stairs, ladders, vertical ladders and in and out of a truck without difficulty. Petitioner reported progressively increasing low back pain with sustained standing and heavier lifting activities. It was recommended that Petitioner return to work within the current abilities. If there was no return to work, than he should consider participation in a four to six week work hardening program with a goal of returning to work full duty. (PX 5/PX 7).

On December 29, 2008, Petitioner saw Dr. Paxton who continued him on Cymbalta for his emotional problems. Petitioner indicated that his back pain was about the same, and not worse. There was still no return of leg pains or symptoms. (PX 6, RX 6).

2009

On January 8, 2009, Dr. Engelhard wrote to Petitioner's attorney, Mr. Cohn, and indicated that while Petitioner was certainly capable of some kind of work, within the Functional Capacity Evaluation limitations, Petitioner was disabled (and he would think permanently) from his former occupation. Of note, the date of alleged accident of December 27, 2007 appears for the first time in this note from the doctor to Petitioner's attorney. (PX 5).

On March 4, 2009, Petitioner saw Dr. Paxton with complaints of neck and back pain. He indicated that he "had not been right for a long time" and that everything seemed to bother him. He further noted that he was not able to do the work he had been trained to do and that almost any activity gave him pain. There were also concerns noted in regard to his mood "not being as good as it was" though he was not sure it was as bad as his wife thought. Dr. Paxton opined that Petitioner did not appear distressed or anxious, prescribed Cymbalta, and diagnosed him with anxiety/depression, back pain/ache, and a herniated disc s/p 10/2008 surgery. Dr. Paxton also opined that Petitioner should follow up with a neurosurgeon. (PX 6, RX 6).

On March 30, 2009, an appointment was scheduled for a DOT physical and release to return to work. (PX 6, RX 6).

On April 7, 2009, the doctor presented to Dr. Paxton and presented for a DOT physical. Petitioner stated that his pain and leg pain were tolerable and that no other medical problems had interfered in the past with his ability to work. Petitioner was diagnosed with back pain, anxiety, and tobacco use disorder. Petitioner was cleared for work. Petitioner was given limitations for driving and encouraged not to do strenuous lifting or activities. (PX 6, RX 6).

On April 10, 2009, Dr. Paxton indicated that Petitioner could return to work on April 13, 2008 [sic] with a limit of 48 hours of driving per week. (PX 6, p. 102).

On April 28, 2009, a medication list was faxed from Dr. Paxton to the nursing station at the Lake County Jail. (PX 6, RX 6).

On October 20, 2009, Petitioner returned to Dr. Paxton and indicated he was having emotional and financial problems and struggling with his divorce. He also complained that his back pain was flaring up though he was no longer having pains in the leg. The doctor diagnosed Petitioner with anxiety/depression, back pain/ache, and a herniated disc s/p 10/2008 surgery. Dr. Paxton also noted that he had no intention of having him on chronic pain medication/narcotics and opined that he should seek counseling and may need to see a pain specialist. (PX 6, RX 6).

2010

On June 15, 2010, Petitioner called Dr. Paxton and indicated he would like to see Dr. Adamson who is in the same office as Dr. Engelhard. A referral was faxed for same. (PX 6, RX 6).

On July 17, 2010, Petitioner saw Dr. Paxton. Petitioner presented with complaints of continued back pain which he had for years. Petitioner indicated that it did not improve since the last visit and that he still had symptoms down the leg. It was noted that Petitioner was in the process of divorce and had financial problems. Petitioner was to restart medication though the doctor stated he did not intend on having him on chronic pain medication or narcotics. Petitioner might benefit from physical therapy and he might need to return to a neurosurgeon. (PX 6, RX 6).

On July 19, 2010, Petitioner called Dr. Paxton seeking Ambien and a muscle relaxer in addition to the Vicodin that he was prescribed. (RX 6).

On July 30, 2010, Petitioner called and indicated that he needed a letter faxed to Dr. Adamson stating that he was still in pain and having numbness. Petitioner also requested a letter. (PX 6, RX 6).

On August 26, 2010, Petitioner saw Dr. James Adamson. Dr. Adamson saw Petitioner through the request of Dr. Paxton. The doctor reviewed the pre-operative MRI and made initial treatment recommendations. Petitioner indicated that he was injured at work in December of 2007. Petitioner was under the care of Dr. Herbert Engelhard thereafter. Petitioner had an MRI of the lumbar spine on January 12, 2008. There was a disc bulge at L3-4 with hypertrophy of the ligamentum flavum and mild central canal stenosis. There was moderate narrow foraminal stenosis on the left side. At the L4-5 level, there was an eccentric bulge to the right and mild hypertrophy of ligamentum flavum. There was also a broad base disc bulge at the L5-S1 level. The doctor had some prior records from when the patient was under the care of Dr. Engelhard. Dr. Engelhard performed the surgery on October 2, 2008. Petitioner had a hemicolectomy of L4 on the right with laminotomies at L3 and L5. Dr. Engelhard explored the discs at L3-4 and L4-5 on the right side and excised free fragments. Petitioner did well after his lumbar surgery with improvement of the right leg pain. Petitioner had a Functional Capacity evaluation in December of 2008. Petitioner then returned to work in April of 2009. Petitioner was taking Vicodin for pain relief. Petitioner reported that his symptoms were worse and that he had shocking pain in the low back in addition to numbness on the right lateral calf. The doctor recommended repeat imaging to determine whether he needed further neurosurgical intervention. Therefore, an MRI of the lumbar spine was ordered. (PX 3).

On August 26, 2010, Dr. Adamson wrote to Dr. Paxton and indicated that Petitioner should have a repeat MRI of the lumbar spine. (PX 3).

Petitioner saw Dr. Gunnar Andersson for a Section 12 Examination at the request of Respondent on September 14, 2010. Dr. Andersson's findings and opinions are discussed hereinbelow with regard to his April 7, 2012 Evidence Deposition. (RX 1).

2011

On June 6, 2011 Petitioner underwent an MRI of the lumbar spine. The MRI was read to reveal mild thoracolumbar scoliosis with lumbar spondylosis and degenerative changes in multiple discs. Postsurgical changes were seen at L4-L5 on the right. (PX 3, PX 9).

On September 8, 2011, Petitioner saw Dr. Lorenz. It was noted that Petitioner was in excellent health while at work and was working on some construction in December 2007. The crane was apparently lowering a large construction bucket of iron, and he was trying to jockey that around into position. Petitioner slipped to the ground while he was pushing this and had immediate onset of pain in the lower back. Petitioner treated

conservatively and ultimately underwent a discectomy at L4-5 on the right. The doctor recommended an MRI. MRI demonstrated old surgical changes at L4-L5 interval. Some degenerative changes were noted at the L3-4, L4-5, and L5-S1 level with some loss of normal hydration. The doctor also noted a 5-mm soft tissue structure at the disc level at the L4-5 interval, which might represent a recurrent disc herniation at that level. The previous MRI did not differentiate between postsurgical scar and recurrent disc. Petitioner was diagnosed with post-laminectomy syndrome and recurrent leg pain. The doctor opined that Petitioner's history was concordant with production of a disc herniation at L4-5. The current symptoms represented complication that at times occurred after post-laminectomy for disc herniation. In particular, Petitioner had segmental instability along with possible recurrent disc at L4-5. Petitioner was taken off work

The "Patient Assessment" completed by Petitioner at Dr. Lorenz's office indicates that he was "referred by Dr. Strongin." (PX 10).

X-rays demonstrated narrowed disk spaces at the L4-5 interval but also to some degree at L5-S1 and L3-4. (PX 10).

Petitioner underwent an MRI of the lumbar spine on September 13, 2011. Postsurgical changes were re-identified at L3, L4, and L5 with right sided laminectomies at the site. No pathologic fluid collections or suspicious areas or enhancement were identified in the operative region. Mild dextroconvex scoliotic curvature of the lumbar spine was noted and no significant spondylolisthesis was seen. The spinal canal appeared congenitally slender. This, in combination with degenerative disc and facet disease, resulted in areas of central canal and neural foraminal narrowing at several levels. (PX 10).

On October 26, 2011, Petitioner saw Dr. Lorenz to discuss the MRI. The doctor indicated that the MRI demonstrated foraminal stenosis predominantly on the left at L3-4, predominantly at the left at L4-5 and also on the right. It was quite severe at L4-5 and L5-S1. The doctor ordered an EMG and nerve conduction study. If Petitioner had ongoing radiculopathy of L4-5 on the right, he might benefit from a decompression of the foreman on that side. He was also given a prescription for follow-up of with a pain management physician (Chicago Pain & Orthopedic Institute). Petitioner was continued off work. (PX 10).

On November 8, 2011, it was noted that the EMG/NCV of the right lower extremity was suspicious for ongoing denervation in the right L4-5 dermatomes, mainly tibialis anterior. Otherwise, chronic L4-S1 polyradiculopathy status post previous surgery. (PX 10).

Petitioner saw Dr. Gunnar Andersson for a Section 12 Examination at the request of Respondent on November 15, 2011. Dr. Andersson's findings and opinions are discussed hereinbelow with regard to his April 7, 2012 Evidence Deposition. (RX 1).

On December 6, 2011, Petitioner presented to the Chicago Pain and Orthopedic Institute for his initial examination. Petitioner underwent a right L3-4, L4-5 and L5-S1 transforaminal epidural steroid injection with selective nerve root block at the Accredited Ambulatory Care by Dr. Jain. (RX 8).

2012

Petitioner returned to Chicago Pain and Orthopedic Institute for an evaluation on January 10, 2012. Petitioner was diagnosed with lumbar post-laminectomy syndrome, lumbar discogenic pain, lumbar facet syndrome, and lumbar spinal stenosis. Petitioner again indicated that he was injured while at work on **December 28, 2007**.

(emphasis added). Petitioner indicated he was pushing a loaded construction bucket with roofing stone when he slipped. Petitioner indicated that he twisted and jarred his back. Petitioner related that he had an onset of back and leg pain. Petitioner indicated that he initially was treated with conservative care but was eventually underwent a discectomy on the right side. Petitioner indicated that did improve but continued with fairly severe low back and right leg pain.

It was noted that an MRI of the lumbar spine was done without contrast on September 13, 2011. The MRI was reported to show evidence for advanced endplate degenerative changes present at L3-4 and L4-5 with multi-level degenerative and facet disease, resulting in areas of central canal and neural foraminal narrowing, including a moderate right and moderate to severe left neural foraminal stenosis at the L3-L4 level. At L4-L5, there was a congenitally slender-appearing canal with bilateral facet arthropathy resulting in moderate to severe right and moderate left neural foraminal stenosis. At L5-S1, there was mild to moderate bilateral neural foraminal stenosis reported and post-surgical changes at L3-4, L4-5 and L5-S1 levels. There are reports highly suggestive of a small disc annular tear at L1-2 and a small right posterior paracentral protrusion at T12-L1. There was a congenitally slender-appearing canal at the L2-3 level. The plan was for a second right L3-4, L4-5 and L5-S1 steroid injections. Pending response to the injections, Petitioner might benefit from right-sided lumbar facet blocks. EMG reports were to be obtained and he was off work. (RX 8).

On January 31, 2012, Petitioner saw Dr. Morgan at Chicago Pain and Orthopedic. Petitioner presented for follow-up care and consultation. Petitioner had a right-sided L3-4 through L5-S1 transforaminal epidural steroid injection on January 17, 2012. Petitioner reported approximately 70% improvement in the back and leg following the procedure and indicated that his back pain increased with bending and squatting. An injection was to be repeated and he was to continue on his current medication regimen. (RX 8).

On February 8, 2012, Petitioner underwent a right L3-4, L4-5 and L5-S1 transforaminal epidural steroid injection with selective nerve root block. Petitioner was diagnosed with lumbar discogenic pain, lumbar facet syndrome, and lumbosacral radiculopathy. (RX 8).

On February 14, 2012, Petitioner saw Dr. Morgan. Petitioner returned for follow-up after a third right-sided lumbar epidural steroid injection on February 8, 2012. Petitioner related that overall he noted no significant improvement. Petitioner related that he continued to experience low back pain and right leg pain and numbness and tingling. Lumbar facet medial branch blocks were discussed as a treatment option. Petitioner was to continue work restrictions per Dr. Lorenz. (RX 8).

On March 13, 2012, Petitioner saw Dr. Morgan at Chicago Pain & Orthopedic Institute. Petitioner was diagnosed with lumbosacral radiculopathy, lumbar facet syndrome, lumbar discogenic pain, and lumbar post-laminectomy syndrome. Petitioner indicated that he had noted improvement with regard to his right leg symptoms since using the Gabapentin, but did continue to experience severe low back pain along with right leg pain and paresthesias. It was noted that Petitioner was using MS Contin, Norco up to four times a day and Gabapentin three times a day and has been using Flexeril three times a day. Treatment was discussed including medial branch blocks once the blood pressure was controlled followed by longer lasting lumbar facet rhizotomies. It was noted that the urine and drug screen at the last visit was consistent with a lab report indicating that he was using Hydrocodone which he was not at the time. Petitioner was to continue with his work restrictions per Dr. Lorenz and follow-up with him as scheduled. (RX 8).

On March 19, 2012, Petitioner saw Dr. Lorenz. The EMG was noted to demonstrate a severe poly neuropathy, particularly at L5 on the right. In addition to that, Petitioner on the MRI demonstrated a severe stenosis at the L4-5 level on the right. Petitioner also had back pain from the degenerative changes throughout the lumbar

spine. The recommendation was a decompression at L4-5 on the right, both at the L4 as well as the L5 root. Petitioner would only undergo repeated surgery if the decompression is extensive to stabilize the spine. Petitioner would remain off-work. (PX 10).

On April 10, 2012, Petitioner saw Dr. Christopher Morgan at Chicago Pain & Orthopedic Center. Petitioner was given Norco and to follow-up with Dr. Lorenz. (RX 8).

On May 8, 2012 Petitioner saw Dr. Morgan. It was noted that Petitioner was awaiting surgery with Dr. Lorenz. Petitioner was off work. Petitioner was diagnosed with lumbar post laminectomy syndrome, lumbar facet syndrome, and lumbar discogenic pain. (RX 8).

On June 5, 2012 Petitioner saw Dr. Morgan. Petitioner was to follow-up with Dr. Lorenz for pain management. Petitioner was to take Norco and use a Fentanyl patch. Petitioner was taken off work. (RX 8).

Petitioner returned to Chicago Pain and Orthopedic on July 3, 2012. Petitioner was diagnosed with lumbar radiculopathy, lumbar facet syndrome, lumbar discogenic pain, and lumbar post laminectomy syndrome. Petitioner was to change his Fentanyl patch every 48 hours instead of every 72 hours. He was to continue the use of Norco with a maximum of 4 per day. He was to continue with use of Gabapentin and Flexeril as prescribed. He was referred for bilateral L3 to L5 and dorsal root of L5 medial branch blocks and, if he showed concordant pain relief, then they would plan on lumbar facet rhizotomies. Petitioner would continue to follow-up with Dr. Lorenz as he was awaiting approval for lumbar spine surgery. (RX 8).

Petitioner underwent bilateral L3, L4, L5, and dorsal root of L5 medial branch nerve block for the facet joint of L3–4, L4–5, and L5 –S1. (RX 8).

On July 31, 2012 Petitioner sought Dr. Jain at Chicago Pain and Orthopedic. Petitioner was to follow-up with Dr. Lorenz for pain management. Work restrictions would be handled by Dr. Lorenz. (RX 8).

Petitioner was seen at Chicago Pain and Orthopedic on August 28, 2012. Petitioner was diagnosed with lumbar radiculopathy, lumbar spondylosis, lumbar facet syndrome, lumbar post laminectomy syndrome, lumbar discogenic pain, and myofascial pain. Petitioner would continue medications he was currently taking. He would continue the Duragesic patch and the Neurontin and Flexeril. Petitioner could increase the Flexeril as tolerated for musculoskeletal pain. Petitioner could also continue Norco for break through pain. It was also discussed that Petitioner might benefit from some trigger point injections in the lower paraspinal muscles over to the right side. Petitioner would continue physical therapy as tolerated and await surgery with Dr. Lorenz. (RX 8).

Petitioner returned to Chicago Pain and Orthopedic on October 2, 2012 area and it was noted that Petitioner continued with pain and was being treated with medications including Duragesic patch, MSIR (Morphine Sulfate Extended Release) in the past, and Gabapentin for musculoskeletal pain. A urine toxic screen was positive for codeine and morphine was detected. The doctor discussed with Petitioner who told him that he was taking some of the MSIR as he had a few left, and he was taking them because he had way for the Duragesic patches. The doctor informed Petitioner that he had to disclose all medications that he was taking when he was on a narcotic regimen per the agreed contract between Petitioner and The doctor. Otherwise, Petitioner would continue medication management including the Duragesic patch, the Neurontin, the Flexeril, and the Norco. They would repeat the drug screen and the doctor again indicated that Petitioner must disclose if he is taking medications that he had at home including the MSIR, which he had in the past. The doctor instructed Petitioner

to not take the MSIR any further and Petitioner agreed. Petitioner would continue physical therapy while awaiting surgery with Dr. Lorenz. (RX 8).

Petitioner returned to the Chicago Pain and Orthopedic Institute on October 30, 2012. Petitioner would continue with medication. The doctor would continue to monitor closely with the urine drug screens to make sure Petitioner was in compliance. Petitioner's last urine drug screen was normal and he would obtain another at the next visit. Petitioner would continue doing physical therapy and gentle stretching that he was currently tolerating. Petitioner was awaiting surgery but otherwise would have medication management only. Petitioner would return in roughly 4 weeks for medication refills but also would discuss with him whether or not surgery would be performed or considered. The doctor explained to Petitioner that there was nothing more he would be able to offer him other than medication management. (RX 8).

Petitioner saw Dr. Jain at Chicago Pain and Orthopedic on December 4, 2012. The doctor recommended bilateral lumbar paravertebral sympathetic block both diagnostically and therapeutically as a palliative measure until surgery is approved. (RX 8).

2013

Petitioner saw Dr. Jain at Chicago Pain and Orthopedic on January 8, 2013. It was noted that Dr. Lorenz had recommended decompression at L4-5 for severe neuropathy and foraminal narrowing. Petitioner wished to proceed with a spinal cord stimulator. The doctor recommended bilateral lumbar paravertebral sympathetic blocks for neuropathic symptoms and then proceeding with the spinal cord stimulator. (RX 8).

Petitioner saw Dr. Jain at Chicago Pain and Orthopedic on February 5, 2013. At that time, Dr. Jain recommended a spinal cord stimulator and took Petitioner off work. (RX 8).

Petitioner saw Dr. Jain at Chicago Pain and Orthopedic on March 5, 2013. At that time, Dr. Jain recommended a spinal cord stimulator and took Petitioner off work. (RX 8).

On March 13, 2013, Chematox Laboratory issued a report with regard to a urine specimen collected on March 5, 2013. It was noted that Morphine, Cyclobenzaprine, Fentanyl, Gabapentin, Hydrocodone, Hydromorphone, and Tramadol were detected but not reported as prescribed. Further combination of Hydrocodone and/or Hydromorphone and Fentanyl, Morphine, and Tramadol might increase risk of CNS and respiratory depression leading to profound sedation, hypotension, or other adverse effects. Combination might also increase risk of constipation and paralytic ileus. (PX 14).

Petitioner returned to Chicago Pain and Orthopedic on April 2, 2013. It was noted that Petitioner's pain had remained unchanged with regard to his low back since the previous visit on March 5, 2013. The doctor recommended bilateral lumbar paravertebral sympathetic blocks for lower extremity neuropathic-mediated pain. The doctor also recommended percutaneous spinal cord stimulator trial. Otherwise he would continue taking Duragesic, Norco, and Neurontin, and Flexeril. Petitioner would remain off work and MMI was undeterminable. (RX 8).

On April 11, 2013, Petitioner saw Dr. Lorenz. Petitioner had complaints of lower back pain. Dr. Lorenz noted that Petitioner had pain radiating down the right lower extremity in an L5 distribution. He had an EMG that demonstrated a polyradiculopathy at L4-5 on the right. He had an MRI which demonstrated severe right-sided

foraminal stenosis at the L4-5 interval. Furthermore, the MRI demonstrated severe degenerative changes at 3-4 and 4-5 which were previously operated and laminotomized levels. In addition, Petitioner was status post L3-4 and L4-5 laminectomy some years ago. Petitioner was diagnosed with segmental instability at L3-4 and L4-5, post-laminectomy syndrome with renewed injury in December 2007. After the operation, his back pain actually worsened, though the leg pain improved. The doctor recommended an L3-4, L4-5 decompression along with a stabilizing fusion at that level. (PX 10).

On April 18, 2013, Petitioner presented to the Lake County Health Department and Community Health Center for a follow-up and lab results. Petitioner was to follow-up with Oana Nisipeanu. (PX 21). There is no indication in these records, or any bills from this provider, that Petitioner presented for any reasons associated with his alleged accident. There are also no referrals contained in the record with regard to this provider.
On April 22, 2013, Petitioner presented to Dr. Fronczak for examination for planned surgical intervention on April 26, 2013. (PX 11).

On April 26, 2013, Petitioner underwent (i.) revision laminectomy of L3-L4, left, with decompression of left L4 nerve roots, (ii.) revision laminectomy of L4-L5, right, with decompression of exiting L5nerve root, and revision laminectomy of L4-L5, left with decompression of the nerve root, (iii.) L3, L4, L5 posterior fusion, (iv.) L3, L4, L5 posterior segmental fixation in order to fix pedicle screws and rods; (v.) iliac crest bone graft harvest, (vi.) implantation of DBM, (vii.) Osteoprogenitor stem cell allograft transplanted, thoroughly thawing and washing; and intraoperative x-rays, interpreted by both surgeons. Petitioner's post-operative diagnoses were status post L3-L4 laminectomy, status post L4-L5 laminectomy, degenerative disc disease at L3-L4, degenerative disc disease at L4-L5 with degenerative scoliosis. (PX 10, PX 23).

On April 30, 2013, Amedisys Home Health Care initiated home health care service. This was certified by Dr. Lorenz. It was noted that Petitioner needed this service as Petitioner required a walker, had an unsteady gait, and was at risk for falling. Petitioner was noted to be status-post decompression and fusion on April 26, 2013. (PX 13).

Petitioner saw Dr. Monika Strand, PA, at Hinsdale Orthopedics on May 16, 2013. Petitioner was s/p L3-5 fusion and decompression on 04/26/2013. It was noted that the right leg pain was essentially gone. The pain in the back was rated at a 7/10. He had some numbness on the lateral aspect of his right thigh. He had home therapy since he was discharged from the hospital due to being unsteady and weak. He felt like it helped him with his ADL's as well as gaining some strength. He continued to ambulate with a walker, allegedly, though he indicated that he forgot it at home. It was noted that he ambulated pretty well without it. X-rays revealed well-placed hardware. Home therapy would continue in order to increase strength and confidence He was to wean off the walker, wear the brace, and remain off work. A follow-up appointment would be in four weeks. (PX 10).

On July 1, 2013, Dr. Lorenz opined that Petitioner remained unable to work. Petitioner was to begin physical therapy, wean from the walker, and return in 6 weeks. (PX 10).

Petitioner presented to Chicago Pain and Orthopedic on July 10, 2013. Since the last visit, Petitioner underwent surgery. Petitioner informed the doctor that after this uneventful surgery the distal lower back pain and lower extremity radiculopathy improved, although he still continued to experience a significant amount distal lower back pain axial pain with associated relevant lower extremity radiculopathy and weakness as well as lower extremity neuropathic–mediated pain symptoms. Dr. Lorenz informed Petitioner that the postoperative course was normal and not to expect a clear tangible improvement in overall symptomology until 6-8 months. Petitioner was requesting refills of all medication. The doctor indicated he would recommend Petitioner follow-

up with Dr. Lorenz for management of the postoperative course. The doctor refilled his prescriptions and would also procure a urine drug screen to assess compliance. Otherwise, Petitioner would remain off work. (RX 8).
On July 29, 2013, Petitioner saw Dr. Lorenz, who noted that Petitioner had started physical therapy. Petitioner was pleased and had noted improvement with his back pain. He no longer complained of leg pain. X-rays revealed that the hardware was in place. A bone stimulator was to be added at that time as well. Petitioner was to remain off work and continue physical therapy. (PX 10).

Petitioner was seen at the Chicago Pain and Orthopedic Center on September 4, 2013. Petitioner was diagnosed with intractable chronic lower back pain syndrome, s/p lumbar spinal surgery and fusion, chronic lower back pain syndrome after lumbar spinal surgery and fusion, and lumbar post-laminectomy syndrome. Petitioner would remain off work and therefore MMI remained undeterminable. (RX 8).

Petitioner underwent additional physical therapy at Accelerated Rehab on September 5, 2013. At that time, Petitioner had the ability to perform bilateral lifting of 31 pounds, bilateral carrying of 25 pounds, bilateral shoulder lifting of 25 pounds, pushing of 40 horizontal force pounds, and pulling of 40 horizontal force pounds. (PX 16).

Petitioner saw Dr. Mark Lorenz on September 9, 2013. It was noted that Petitioner was coming along "reasonably well" despite one setback in physical therapy when he stepped to the side and developed some increased buttock pain at the site of the graft. X-rays revealed hardware in place and a slowly progressing fusion. Petitioner was to remain off work and continue physical therapy. He was to advance to work conditioning. (PX 10).

On October 18, 2013, Accelerated Rehab issued a progress report. It was noted that he attended 40 appointments, canceled 2, and rescheduled 3 appointments. Petitioner would continue physical therapy 3 times a week for 12 weeks. (PX 16).

Petitioner was seen at Hinsdale Orthopedics on October 21, 2013. Petitioner reported that his lower back still got tight, with a sharp stabbing pain. Petitioner also experienced left and right leg cramps. Physical therapy was noted to be helpful to Petitioner. X-rays demonstrated degenerative changes throughout the lumbar spine, but advancing fusion and proper hardware placement. The doctor indicated that he would like Petitioner to scale back and try to achieve a light level of activity only. He would do therapy for another 3 weeks and then a functional capacity assessment and return at that point time. Petitioner would remain off work. The "DOI" on the Work Status Report was noted as "12/28/2007." Petitioner was again deemed unable to work. Petitioner was to return on November 25, 2013. (PX 10).

Petitioner presented Chicago Pain and Orthopedic on October 30, 2013. Petitioner continued to complain of significant distal lower back axial pain with associated neuropathic lower extremity pain and radiculopathy. The doctor issued a refill of all prescriptions but would procure a drug screen to assess compliance. (RX 8).

Petitioner underwent a Functional Capacity Examination on November 19, 2013. Petitioner demonstrated the ability to perform 40.9% of the physical demands of his job as a gravel truck driver. He demonstrated the ability to perform within the light physical demand level based on the definitions developed by the Department of Labor and outlined in the dictionary of occupational titles. (PX 16).

On November 25, 2013, Petitioner was seen at Hinsdale Orthopedics. Petitioner reported complaints of mid-thoracic pain, numbness to the lower back that radiated to the left glute, and right leg pain with numbness. It

was noted that Petitioner had an FCE which placed him at a light physical demand level. He was restricted to an occasional 20 pound lift. X-rays revealed an advancing posteoerolateral fusion at L3-5. There was lucency around the hardware at L3 on the right. Petitioner was diagnosed with s/p L3-5 fusion, with possible hardware irritation. Petitioner was return to modified duty as of November 26, 2013 limited to no lifting greater than 20 pounds, occasionally, sitting for one or/standing 20 minutes, and occasional bending/squatting/kneeling. It was noted that these were permanent light duty restrictions pursuant to FCE results. Petitioner would return after the CT scan. The "DOI" on the Work Status Report was noted as "12/28/2007." (PX 10).

2014

Petitioner returned to Chicago Pain and Orthopedic on January 8, 2014. Petitioner at this time was diagnosed with intractable chronic lower back pain syndrome, lumbar post laminectomy syndrome, status post lumbar spinal surgery and fusion, status post revision surgery, and chronic opioid intake. Petitioner continued to complain of pain despite around-the-clock intake of opioid and non-opioid analgesic medications. The doctor did refill the prescriptions but again noted that he would obtain a urine drug screen. (RX 8).

Petitioner underwent a CT of the lumbar spine on January 22, 2014. The CT scan was read to reveal postoperative changes from the spinal fusion between the L-3 and L-5 levels. The hardware was intact and was in its usual position. There was a bone graft material at the lateral sides of L3-L5, which was incompletely fused, and moderate spinal stenosis at the L2-L3 level. There were also areas of foraminal stenosis as described. (PX 10, PX 22no).

Petitioner saw Dr. Lorenz on February 10, 2014. He was doing well, though continued to have pain, predominantly at the left hip at the site of the graft. He had sensation of pressure in his back, but really no pain. Petitioner had occasional cramping in the right lower extremity at this visit. A CT scan was reviewed which demonstrated some continuity of both from L4 down to S1. Petitioner's hardware was properly placed. There was no significant stenosis. The superior screws did demonstrate some resorption. Flexion-extension view demonstrated essentially no movement. The doctor opined that Petitioner's symptoms were more related to the lower graft site than to the hardware. He recommended that Petitioner continue with physical therapy and remain off work. He would return in two months for another evaluation. If it becomes a problem, removal of the hardware and fusion exploration might be indicated. (PX 10).

Petitioner returned to Chicago Pain and Orthopedic on March 19, 2014. The doctor refilled prescriptions and noted a drug screen. (RX 8).

On April 4, 2014, Dr. Lorenz issued a report nothing that Petitioner initially saw him on September 8, 2011. Petitioner reported at that time that he was in excellent health while working in December of 2007. Apparently, during that time, a large crane construction bucket made of iron that he was trying to jog into position and while he was doing so, slipped on the ground while pushing. He had immediate onset of pain in the lower back. This dated back to December of 2007. He initially was treated conservatively for his back and leg pain and then ultimately underwent a discectomy at L4-L5 on the right side having been identified and as having a disc herniation with radiculopathy. Petitioner had some improvement of his leg symptomology. However, the back pain never really improved. In addition to that, Petitioner had a double hernia repair in 2008. Petitioner indicated that his therapy was somewhat slowed down secondary to that procedure. Petitioner continued to have ongoing pain in the lower back. He started to develop radicular symptoms on L-5 nerve root and felt the lateral calf.

At the initial visit, Petitioner had pain in the lumbosacral junction with bending and extension suggestive of segmental instability of the lumbar spine. He had reversal rhythm as well supporting the diagnosis of segmental instability clinically. In addition to that, Petitioner had a positive straight leg raising on the right side of 45°, negative on the left. X-rays obtained at that time demonstrated some disc space narrowing, consistent with an old herniation that was first treated surgically at L4-L5 in 2008.

Petitioner's MRI demonstrated the old surgical changes at the L4-L5 interval. In addition, Petitioner had a 5 mm soft tissue structure posterior to the disc at L4-L5, which represented a recurrent disc herniation at the same level.

Petitioner was recommended to undergo additional surgery to solve his problems. Petitioner did undergo a revision disc herniation at the L4-L5 interval excision. Petitioner furthermore was recommended to undergo an L4-L5 fusion since he had significant back pain. It was the doctor's opinion that the treatment done consisting of a revision discectomy and decompression, as well as fusion, was not only clinically necessary, but was tied to the original injury in 2007 when he sustained a disc herniation while at work. As a result of continued treatment, Petitioner has been prescribed physical therapy and recommended to have a spinal cord stimulator.

Based on the doctor's opinion, in effect, the disc herniations at times cause re-herniations and back pain with segmental instability as a complication of the original injury. All treatment subsequent performed including pain management is therefore a sequalae of the injury that Petitioner sustained on "December 7th" while jogging the bucket into position and slipping when his back pain initiated. (PX 10).

Petitioner returned to Dr. Lorenz on April 7, 2014. Petitioner reported that he was improved following the surgery, but that he still had pain. Activities increased the pain. Dr Burgess had recommended a spinal cord stimulator, which is an option that should be considered, according to Dr. Lorenz. Petitioner was to remain off work, stop physical therapy, and return in three months for re-evaluation. (PX 10).

Petitioner returned to Chicago Pain and Orthopedic on May 14, 2014. Petitioner would continue to follow-up with Dr. Lorenz for postoperative care. The doctor noted that Petitioner's options were limited. On one hand, Petitioner was resistent to pursue further surgery. On the other hand, managing his chronic low back axial pain and associated lower extremity radiculopathy and neuropathic pain with increasing dosages of oral opiates was not the classical standard of care, and his refractory back pain and associated lower extremity radiculopathy and neuropathic pain all failed to respond to conventional treatment, interventional pain management, central–axis procedures, surgery and pharmacological treatment. The doctor recommended that a placement of a dorsal column spine stimulator could be an option. Otherwise, the doctor refilled prescriptions. (RX 8).

On June 25, 2014, Petitioner returned to Chicago Pain and Orthopedic. Petitioner was diagnosed with intractable chronic lower back pain syndrome, lumbar post laminectomy syndrome, status-post lumbar spinal surgery and fusion, status-post revision surgery, and chronic opioid intake. It was noted that Petitioner was last seen on May 14, 2014. Petitioner was noted as status quo after lumbar spinal decompression surgery and fusion performed by Dr. Lorenz on April 26, 2013. Petitioner continued to complain of significant amount of incapacitating distal lower back axial pain with associated lower extremity radiculopathy symptoms as well as persistent lower extremity focalized weakness and neuropathic pain to both lower extremities.

The doctor noted that a recent x-ray obtained earlier revealed a lucency around the hardware at the L-3 segment on the right. Under this light, Dr. Lorenz recommended Petitioner to pursue a CT scan to assess the pendency of

the fusion but also to determine whether this lucency had any relation with the ongoing chronic persistent pain despite surgery. The CT scan of the lumbosacral spine on January 22, 2013 showed an incomplete fusion at the level of L3–L4 and L4–L5 on the lateral side. There was moderate to severe L2–L3 spinal stenosis. Petitioner would see Dr. Lorenz in several weeks to discuss his options.

The doctor had a lengthy discussion with Petitioner regarding the opioids. The doctor explained how the chronic intake of narcotics and opioids in the management of chronic discogenic back pain with associated radiculopathy is not the standard of care. On one hand, chronic intake of narcotics and opioids is laden with side effects including addiction but on the other hand narcotics do not exert any anti-inflammatory properties on living tissue. The actual cause of chronic intractable discogenic lower back pain and associated radiculopathy is in essence that a chronic inflammation of the nerve roots as well as the medial branch nerves from inflammatory mediators released in the milieu of the surrounding tissues, and narcotics tend to not have any substantial impact on the physiopathology of the disease. As such, the doctor planned to discontinue the chronic intake of narcotics as he felt that Petitioner might benefit further from a combination of nonsteroidal anti-inflammatory medication such as COX–2 inhibitors as well as Meloxicam in combination with muscle relaxants, neural modulation, and a non-opioid analgesic medication. Petitioner would need to initiate an adequate opiate tapering protocol. Petitioner would need to work with an addiction specialist who is experienced in weaning people off opiates and understood that there would be a period of withdrawal symptoms whether it's done rapidly or through weaning over a period of weeks.

Petitioner would follow-up with Dr. Lorenz for management of his postoperative lumbar spinal decompression surgery and fusion and to discuss whether he would need a revision surgery. It was noted that if Petitioner was not a candidate for revision surgery, then he would need to proceed with this dorsal column spinal cord neural stimulation. The doctor noted that Petitioner's options were limited. On one hand, he was resilient to pursue further surgery. On the other hand, managing his chronic lower back pain and associated lower extremity radiculopathy and neuropathic pain with increasing dosages of oral opiates is not the classical standard of care, as his refractory back pain and associated lower extremity radiculopathy and neuropathic pain all have failed to respond to conventional treatment, interventional pain management, central axis procedures, and surgery.

As such, Petitioner's options included the placement of the spinal cord stimulator designed to help patients with chronic resilient and refractory pain syndromes after failed spine surgeries. Petitioner would remain off work as recommended by Dr. Lorenz and MMI remained unclear. (RX 8).

Petitioner saw Dr. Gunnar Andersson for a Section 12 Examination at the request of Respondent on October 28, 2014. Dr. Andersson's findings and opinions are discussed hereinbelow with regard to his January 30, 2015 Evidence Deposition. (RX 5).

Petitioner was seen at Great Lakes Pain Physicians on November 20, 2014. There is no referral to this facility or doctor contained in the medical record. This would constitute Petitioner's third choice of physician. Petitioner was following up for chronic low back pain which was allegedly due to an October 2008 work injury. Petitioner indicated that he was driving a truck to load a crane with some cement when he injured his back. It was noted that Petitioner had an EMG which revealed damage at the right L5–S1 nerve and that he was treated with conservative measures including pain medication, physical therapy, and lumbar epidural. According to the history, symptoms, and examination, the anesthesiologist diagnosed Petitioner with persistent low back pain, lumbar facet arthropathy, herniated discs at L4-5 and L5-S1 and right L5-S1 radiculopathy. It was noted that there was no prior history or MRI for comparison. The doctor reinforced proper spine mechanics, posture, and pacing of activities with Petitioner. The doctor recommended an RF lumbar facet medial branch injection and

Petitioner was given a prescription for same. Petitioner would follow-up in 2 months while increasing his Keppra to 500 and continuing MSER, Norco, Ambien, Keppra, and Duexis. (PX 24).

2015

Petitioner was seen at Great Lakes Pain Physicians on January 10, 2015. It was noted that Petitioner presented for a visit due to work-related low back pain. Petitioner reported that "in October 2008 while driving a truck to load a crane with some cement he injured his back." Petitioner reported his pain was improved with rest and medication, but increased with walking, bending, and squatting. He did not use assistive devices. Petitioner reported that he had injections several months prior which gave him good relief for about three months. But then, a pain reappeared in the back, and on and off to the right leg. Petitioner also noticed shooting pain intermittently to the left leg. Petitioner was diagnosed with chronic low back pain, right L-5 radiculopathy, lumbar disc herniation at L4–5, lumbar facet arthropathy and status post laminectomy. Petitioner was to continue the MSER (Kadian – morphine sulfate), Norco, Keppra, and Zanaflex. He would also restart Duexis and re-start physical therapy. Petitioner would follow-up in one month. (PX 24).

(ii.) Testimony of Dr. Mark Lorenz (PX 26)

March 7, 2012 Evidence Deposition (PX 25)

Dr. Mark Lorenz, one of Petitioner's treating physicians and a board certified orthopedic surgeon, was deposed on March 7, 2012. Dr. Lorenz testified as to the first visit with Petitioner on September 8, 2011, as noted above. (PX 26, p. 7). Dr. Lorenz testified that his examination revealed two abnormal findings: (i.) an instability in his lower back with pain and an inability to position himself in space in a normal way, and (ii.) an L5 radiculopathy with abnormal sensory issues along the L5 dermatome to the lateral part of the calf, and a positive straight leg raising on the right side at 45 to 50°. (PX 26, pp. 8-9). Dr. Lorenz reviewed x-rays that he ordered to reveal narrowing of the disc spaces, the L4-5 interval in particular, but also to some degree at L5–S1 and L3–L4. The previous laminotomy site was evident on the x-ray. (PX 26, pp. 9-10).

Dr. Lorenz also testified that Petitioner's reported pain on September 8, 2011, measured on the visual analog scale, was a 10 and meant that his pain unbearable and the highest level that one could demonstrate. (PX 26, p.10). Dr. Lorenz also noted an MRI that was taken subsequent to the surgery which revealed degenerative changes with soft tissue issues at the right side at L4–L5 which the doctor thought might represent a recurrent disc herniation. (PX 26, p. 11). However, Dr. Lorenz admitted that he did not see the preoperative MRI. (PX 26, p. 12). After the examination, the doctor ordered a repeat MRI to further investigate the narrow area at the L4–5 interval. He also felt that Petitioner needed an EMG/NCV to determine whether or not he had ongoing progressive nerve irritation. (PX 26, p. 12).

The EMG was done on November 8, 2011, as noted above, and the doctor found that the important finding was that of ongoing denervational findings at L4–5 on the right. This suggested that there was ongoing obstruction to the nerve due to a combination "probably of reherniation" in addition to some scar tissue and perhaps dynamic movement of the vertebra slipping. The nerve continued to deteriorate based on pressure on the nerve. (PX 26, pp. 12-13). At the time of the deposition, The doctor had not seen Petitioner since the EMG was done but testified that he would tell Petitioner that he had an ongoing nerve problem the probably would need revision surgery. (PX 26, p. 14).

Dr. Lorenz testified, despite first examining Petitioner almost four years after the alleged accident, that he believed that the alleged accident of December 2007 might or could have caused the condition as described. Petitioner's history of moving a heavy object and slipping, being an awkward position with sudden weight transfer, would be consistent with the disc herniation. (PX 26, p. 15)

Dr. Lorenz testified again that if Petitioner returned to see him that he would tell him that he had a neurologic problem, a nerve problem which was due to pressure on the nerve at the L4-5 interval and would need a revision decompression. The doctor would further tell Petitioner that he would need a fusion surgery as well because the ongoing back pain. (PX 26, p. 17). This opinion is based on two visits: September 8, 2011 and October 26, 2011 as well as the September 13, 2011 MRI and the November 8, 2011 EMG.

Dr. Lorenz opined that the laminectomy that was done did not adequately solve Petitioner's issues. He then had a complication in that the disc degenerated further resulting in pain. Dr. Lorenz opined that after laminectomies, 5% to 10% of patients would go on to significant severe back pain with ultimate fusion. Up to 30% of patients could have recurrent disc herniations. (PX 26, p. 20).

Dr. Lorenz was unable to opine with regard to medical causal connection of Petitioner's hernia from 2008, or three years before he first examined Petitioner. (PX 26, p. 23). When questioned further regarding the 5 mm soft tissue structure, Dr. Lorenz opined that this was a piece of disc back in the canal. However, Dr. Lorenz was unable to opine as to whether or not it was a recurrence and reherniation following the discectomy, or whether or not Petitioner had a partial removal. (PX 26, p. 24).

On cross-examination, Dr. Lorenz testified that, upon review of his records, that Petitioner was referred to him by Dr. Strongin of whom he was unfamiliar. (PX 26, p. 25). Dr. Lorenz testified that he did not know how heavy the object was he was "trying to jockey" on the alleged date of accident. He did believe that the bucket was not on the ground, but was swinging in the air. (PX 26, p. 28). Dr. Lorenz did not know what was allegedly in the bucket, or whether it was filled partially or totally. (PX 26, p. 28).

Dr. Lorenz testified that he could only rely on the history given to him by Petitioner, and "a physician always assumes that the patient will tell you the truth in regard to his symptoms and the origin of the symptoms and the activities that brought them on and his current state." (PX 26, p. 32). So, he was assuming that the history given him by Petitioner was 100% correct and that "if the patient lied and there was something completely different, I might change my mind." (PX 26, p. 32).

Dr. Lorenz did not request to see Petitioner's past medical records and only had interest in the operative report prior to surgical intervention for "technical reasons" and unrelated to causation opinions. (PX 26, p. 34-35). Dr. Lorenz admitted that the VAS pain scale is based on what Petitioner reports his pain to be, only. (PX 26, p. 37).

Dr. Lorenz admitted that the only MRI that he reviewed was the one taken on September 13, 2011. He did not review any previous radiographic studies. (PX 26, p. 39).

Dr. Lorenz admitted that the September 13, 2011 MRI revealed degenerative changes at L3-L4, L4–L5, and L5–S1. Dr. Lorenz testified that those findings were representative of cumulative injuries that occurred over a lifetime with the disk having an inability to maintain its hydration status. The doctor opined that Petitioner may have had this finding, in other words dehydration of the disc, even before the alleged accident in December 2007. (PX 26, pp. 39-40). Dr. Lorenz testified that Petitioner had a recurrent herniation and foraminal stenosis with clear-cut compression of the nerve, but he did not know when the foraminal stenosis began. Dr. Lorenz

opined that he could not pinpoint when the foraminal stenosis started as he did not have an MRI to point to. (PX 26, p. 42).

Dr. Lorenz testified that the significant narrowing and advanced endplate degenerative changes at L3–L4 and L4–L5 was caused by wear and tear, injuries, cumulative injuries, surgical procedures, singular trauma or "all kinds of things." (PX 26, p. 46). Dr. Lorenz testified that the issue was mostly at L4–L5 which would be related to his understanding and interpretation of the alleged injury with the herniation and revision. (PX 26, p. 47).

(iii.) Testimony of Dr. Gunnar Andersson (RX 1 & RX 5)

a. April 7, 2012 Evidence Deposition

Dr. Gunnar Andersson, Respondent's Section 12 Examiner and board certified orthopedic surgeon, was deposed on April 9, 2012. Petitioner reported to Dr. Andersson on the date of his initial examination on September 14, 2010, that he was injured on December 28, 2007 while receiving buckets of stone delivered to him by a cranes and then pushing the buckets and the stones into the chute of the back of the trailer. In the process of doing that, Petitioner reported that he developed back pain, which gradually worsened over the next ten days, requiring an Emergency Room visit on January 7, 2008. (RX 1, p. 8).

Dr. Andersson reviewed the January 8, 2008 record which revealed that Petitioner had a gradual and increasing pain the low back. Dr. Paxton ordered an MRI as Petitioner complained of left leg pain, which was performed on January 12, 2008. There was evidence of spinal stenosis, mainly at L3-4. (RX 1, p. 9).

Petitioner was referred to Dr. Engelhard, who examined him on January 24, 2008. That doctor opined that Petitioner was suffering from spinal stenosis and that he should treat with medication and steroid injections. Petitioner reported to Dr. Andersson that he underwent injections in February, March, and April 2008, but his problems were not resolved. He then had problems with an abdominal hernia around that time. (RX 1, p. 9).

Petitioner returned to Engelhard in May 2008, had a new MRI in July that was unchanged and then in October 2008 underwent hemilaminectomies at three levels of the lumbar spine, and discectomies at L3-4 and L4-5 on the right side. Petitioner then underwent physical therapy and improved. He then underwent a functional capacity evaluation and December 2008 and was found to be able to work with a 50 pound restriction, which was below the requirements of his job He was advised to return to work with restrictions. It appears that he did return to work in April 2009 and that he worked until January of 2010 when he was laid off. (RX 1, p. 10).
Dr. Andersson testified that he reviewed the January 12, 2008 MRI film personally and found it to show degenerative changes throughout the lumbar spine with spinal stenosis at two levels. The spinal canal was generally congenitally narrow, which meant that Petitioner was born with a narrow spinal canal. (RX 1, p. 11).

With regard to Petitioner's physical examination, Dr. Andersson testified that Petitioner walked normally and had a normal posture. There was no tenderness in the back. There was a decreased range of motion, negative straight leg raise, normal reflexes, motor and sensory functions and lower extremities, normal hip range of motion, and negative nonorganic physical sensation. Dr. Andersson testified that Petitioner had complaints of pain in the lower back and some numbness in the right calf area. The doctor opined that there were no objective findings as with spinal stenosis, there rarely are any objective findings. (RX 1, pp. 11-12).

At the time of this initial examination, Petitioner was diagnosed with post-hemilaminectomy from L3 to L5, which was surgery that he underwent in October 2008. Otherwise, there was no active diagnosis. (RX 1, p. 12).

Dr. Andersson testified that the initial medical records did not support the idea that there was a specific injury, but rather suggested that Petitioner's symptoms developed gradually and progressively. (RX 1, pp. 12-13). Dr. Andersson pointed out that Petitioner had treatment both in the Emergency Room and by Dr. Paxton in early January 2008, however did not specifically state that he had a work-related injury. (RX 1, p. 13). It was not until he saw Dr. Engelhard that the history as described to Dr. Andersson was revealed. Dr. Andersson opined that a doctor had to have some information about the nature of the accident and the timing of the accident in order to opine with regard to causation. However, the doctor opined that it probably was not that critical because the spinal stenosis that Petitioner had did not result from the accident but was rather the result of degenerative changes over a long period of time. (RX 1, p. 13).

When asked to assume that Petitioner's history of accident *as reported to him* at the examination was accurate, and opine what diagnosis or injuries were caused, aggravated, or accelerated by the alleged work accident of December 28, 2007, Dr. Andersson opined that he was "not sure that any were." (RX 1, p. 14). However, the doctor opined that it was possible, by the type of activity that the Petitioner described, to temporarily aggravate the pre-existing degenerative and stenotic problem. (RX 1, p. 14). When asked when Petitioner would have reached maximum medical improvement with regard to the temporary aggravation, the doctor again opined that he was not sure that Petitioner actually had a work-related injury, but in any event did reach maximum medical improvement by the time he was released to return to work and by the time he returned to work in April 2009. (RX 1, p. 14). As such, at the time of this examination, Petitioner remained at maximum medical improvement with respect to any alleged accident. (RX 1, p. 14).

Dr. Andersson also opined that the surgery in October 2008 would have been necessary no matter what, but not related to the alleged accident. However, at the time of the initial examination, Dr. Andersson opined that Petitioner did not need any additional medical treatment, whether or not it was regarding a work-related accident or a non-work-related condition. (RX 1, p. 15).

Dr. Andersson opined that Petitioner was capable of working and that he could return to work with restrictions of occasional lifting of 50 pounds and repetitive lifting of 25 pounds, but those restrictions were related to the congenital disease and underlying disorder, not any work-related accident, as of the date of the initial examination. (RX 1, p. 15).

Dr. Andersson then testified regarding his November 15, 2011 examination of Petitioner and noted that at that time he reviewed subsequent medical records which included those of Dr. Lorenz. (RX 1, pp. 15-16).

Dr. Andersson testified that the records that he reviewed revealed that a September 2011 MRI showed no evidence of recurrent herniation but that there was continued foraminal stenosis on the left side at L3–L4 and on the right side at L4–L5, and that Dr. Lorenz discussed possible further care. Dr. Andersson, after reviewing the MRI film personally, opined that Petitioner continued to have mild to moderate stenosis on the right side L3–4 and L4–5. (RX 1, p. 17). Dr. Andersson also opined that there were disc bulges (circumferential enlargements of the disc which either occur because the disc is healthy and has been loaded or because of degenerative changes which causes narrowing of the disc and therefore some bulging of disc tissue) with degenerative changes, but there were no herniations (a crack in the wall of the disc with the focal protrusion of disc material). Dr. Andersson opined that the disc bulges in the September 2011 MRI were strictly degenerative and existed in Petitioner's MRI from 2008. (RX 1, p. 18).

Dr. Andersson then testified that Petitioner complained that he had pain in the lower back with radiation to the outside of the right leg at the 2011 examination. Petitioner also complained of numbness and tingling in the legs as well. (RX 1, p. 19). At the 2011 examination, Dr. Andersson diagnosed Petitioner with degenerative changes of the lumbar spine and stenosis, foraminal stenosis on the right side. This was essentially the same diagnosis after the first examination. (RX 1, p. 20).

Dr. Andersson again testified that Petitioner reached maximum medical improvement in April of 2009. It also remained his opinion that the foraminal stenosis was not related to any alleged accident. However, Dr. Andersson did find that the treatment that Petitioner underwent between the two Section 12 examinations (September 14, 2010 and November 15, 2011) was reasonable though not related to any alleged work injury. (RX 1, p. 21). After the 2011 examination, Dr. Andersson thought Petitioner might require some treatment for the underlying problem, but not with respect to any alleged work accident. Again, the doctor released Petitioner to work restricted to no lifting more than 50 pounds. However, said restrictions were not related to the work accident. (RX 1, p. 22).

Dr. Andersson was then cross-examined and asked whether it was his feeling that Petitioner did or did not sustain a work-related accident. Dr. Andersson opined that he did not know for sure, but thought it unusual that one would have a work-related accident and not describe to the first two physicians who examined him [Vista Medical Center and Dr. Paxton], and then suddenly described to the third [Dr. Engelhard]. (RX 1, p. 34). Dr. Andersson testified that he looked at the January 8, 2008 record from Dr. Paxton which noted that Petitioner was a truck driver and that he presented with right leg pain which started last week. It noted that Petitioner believed it was from his work, but he did not have any specific injury or incident that precipitated the symptoms. He had some back pains before but not leg pain. Dr. Andersson opined that this was supportive of the idea that Petitioner actually never had accident. (RX 1, pp. 37-38).

Dr. Andersson then discussed the stenosis, and again opined that Petitioner had a combination of the congenitally narrow canal and a developmental spinal stenosis which had developed over a long period of time. The doctor conceded that he had no indicated that there were any x-rays, MRIs, or any documentation of any back pain prior to December 2007, but did note that there was always a first time when a patient complains, as one is rarely born with pain and continue to have pain. At some point it becomes symptomatic for whatever reason. (RX 1, p. 39).

Dr. Andersson was then asked if he was given a history from Petitioner that there was an onset of injury on December 28, 2007. The doctor agreed and cited Exhibit 5 to the deposition. (RX 1, p. 41, ex. 5).

Dr. Andersson testified that he remembered reading the hospital records [January 7, 2008], and that they said there was no specific injury. (RX 1, p. 50). Dr. Andersson was again asked to confirm that he noted a date of injury as December 28, 2007 upon the initial examination, based on information given to him by Petitioner. (RX 1, p. 51).

Dr. Andersson opined that the basis of his opinion that Petitioner's complaints at the initial examination were not related to an accident of December 28, 2007 was that Petitioner had reached maximum medical improvement in April 2009 when he returned to work. (RX 1, p. 59). Dr. Andersson opined again that whether Petitioner had an accident or not, which he thought he did not, or whether he had an underlying condition that was aggravated, which he thought he did, Petitioner was treated and released and reached maximum medical improvement in December 2008 by his treating physician. (RX 1, pp. 59-60). .Aside from his belief that

Petitioner did not actually have an accident, Dr. Andersson opined that Petitioner was treated, returned to work, and did not complain of his symptoms for a whole year. (RX 1, p. 60).

Dr. Andersson opined that it is true that 30% of patients following surgery get worse and need additional treatment, but that is because the surgery was likely not indicated in the first place. Dr. Andersson testified that Dr. Engelhard performed the surgery that he thought would resolve Petitioner's problem by addressing the underlying condition, which was spinal stenosis, and that surgery was successful in the sense that it relieved the symptoms and allowed him to return to work for almost a year without problem. (RX 1, p. 62).

Dr. Andersson opined that Petitioner's problems following December 28, 2007 were a result of the congenital narrowing of the spine and the degenerative changes that have occurred over the years. (RX 1, p. 67). Dr. Andersson also opined that at the 2011 examination, there was nothing specific in the examination is supported leg pain complaints. (RX 1, p. 70). Specifically, the straight leg raise was normal. The doctor again opined the stenosis was a slowly progressive disorder and can cause symptoms from time to time but had has nothing to do with work. (RX 1, pp. 71-72).

Dr. Andersson at agreed with Doctor Lorenz's diagnosis of post laminectomy syndrome with back pain and recurrent leg pain. However Dr. Lorenz failed to explain what the underlying problem is. (RX 1, p. 77). Dr. Andersson disagreed with Dr. Lorenz's opinion that Petitioner's history was concordant with the production of a disc herniation at the L4-L5 interval. The doctor disagreed that it was based on history, and that the herniation was present. (RX 1, p. 77). Dr. Andersson did not think that Petitioner had any complications from the operation. There was no evidence in the MRI of any complications. (RX 1, p. 78).

Dr. Andersson also disagreed with Dr. Lorenz's opinion that Petitioner had segmental instability along with possible recurring disc at L4–L5. This was based on his examination and his evaluaton of the imaging studies that Petitioner underwent. The entire physical examination was inconsistent with an instability. The x-rays obtained by Dr. Lorenz in September 2011, which included flexion/extension views were inconsistent with instability. There was no evidence of any instability on any of the MRI scans. (RX 1, p. 79).

Dr. Andersson was asked about Petitioner's habit of smoking a pack of cigarettes a day for 20 years and opined that there is a strong relationship between degenerative disc disease and smoking and that smoking predisposes one to degenerative changes. (RX 1, p. 86).

b. January 30, 2015 Evidence Deposition

Dr. Andersson was deposed a second time on January 30, 2015. He testified that he retired and stopped seeing patients on January 1, 2015. For the ten years prior, his practice was non-operative in nature and if a patient needed surgery, he would refer them to one of his partners. Nonetheless, he remained a board-certified orthopedic surgeon and Illinois. (RX 5, p. 5).

This deposition was in regard solely to his independent medical examination of Petitioner that took place on October 28, 2014. (RX 5, p. 7). In conjunction with the examination of petitioner, Doctor Andersson reviewed records from Dr. Lorenz and Chicago Pain and Orthopedic Institute. (RX 5, p. 8). Dr. Andersson noted that upon examination, Petitioner walked with a limp but that was primarily due to a recent right foot surgery. Petitioner was also to undergo surgery and left foot as well. Petitioner used a cane to support him and was using a brace for the lower back. (RX 5, p. 9). Petitioner had increased lordosis in the lumbar spine and slight tenderness on palpation. He had very poor range of motion and the only motion he had was from 0 to 10° of

flexion. He had negative straight leg raise, normal lower extremity reflexes, and normal motor function. Petitioner also had some sensory changes on the right side which corresponded primarily to the distribution of the L5 nerve. What this meant is that due to the surgery will involving the L5 nerve, there was some remaining absence of feel or change in feel corresponding to the distribution of the nerve. (RX 5, p. 10).

Dr. Andersson also reviewed x-ray films from September 8, 2011; May 16, 2013; July 1, 2013; July 29, 2013; and September 9, 2013. The first x-ray was preoperative showing degenerative changes. The other x-rays were postoperative, showing a fusion extending from the L3 vertebra to the L5 vertebra. He did not see any evidence that any of the instruments had come loose following the fusion That indicated that whether it was fused or not, it was not moving significantly because otherwise the hardware would come loose. (RX 5, p. 11).

Following his examination of Petitioner as well as review his records and films, Petitioner was diagnosed with status post fusion from L3 to L5, with the reason for the fusion being the underlying degenerative disc disease and spinal stenosis. The doctor believed that the fusion might not have taken. It was Dr. Andersson's opinion that neither diagnosis, the degenerative disc disease or spinal stenosis, were caused, aggravated, or accelerated by the (at that time) alleged December 28, 2007 accident. Dr. Andersson reiterated the fact that there was never really any documentation of an actual accident until about a month following the alleged accident date when Petitioner started describing the accident. Up until that point, he had not described an accident and his records reflected that his symptoms and gradually increased over time. Further, there was nothing in the imaging studies to suggest that Petitioner had an accidental problem to the back; rather, Petitioner had an underlying congenital stenosis and degenerative changes, which were known to gradual increase over time. (RX 5, p. 12-13).

Further, even if the alleged accident occurred as Petitioner later reported to his physicians and to Dr. Andersson, it would not change Dr. Anderson's opinion that the underlying stenosis and degenerative changes would not be causally related to the accident. The injuries were not accidental, based solely on the nature of the diagnoses. Therefore, the surgeries were related to the underlying degenerative and stenotic condition. (RX 5, p. 13).

As in his first deposition, Dr. Andersson testified and opined that Petitioner would have reached maximum medical improvement when he returned to work in the spring of 2009. (RX 5, p. 14). No treatment at all was related to an accident according to the opinions of Dr. Andersson, but even assuming that it had, Petitioner seemed to have recovered by March 2009 and he returned to work in April 2009. (RX 5, p. 14).

Dr. Andersson also opined that at the time of the examination in October 2014, Petitioner did not require any further medical treatment, regardless of causation issues. This was based on Petitioner telling the doctor that he did not want any additional surgical or other invasive treatment. Further, Petitioner's problem was not one that required surgery or interventional treatment. Being his decision, there was no need for any further care and the only issue was that Petitioner had been on narcotic medication for a long time which caused addiction. So, in order to address that problem, Petitioner would need to undergo medical treatment to alleviate the addiction. (RX 5, p. 15). Actually, when asked, hypothetically, if a Pain Center opined that Petitioner needed to wean off medication narcotics he would find that a reasonable approach. (RX 5, p. 16).

Dr. Andersson was also asked regarding his opinion that Petitioner was not capable of working at the time of the October 2014 examination. Dr. Andersson explained that his opinion was based on the fact that Petitioner was receiving heavy narcotic medication would prevent him from working. Otherwise, the inability to work was in no way causally related to an alleged December 28, 2007 accident. (RX 5, p. 17).

On cross-examination, Dr. Anderson testified he is not surprised that a "50-some-odd-year-old gentleman" would have degenerative changes. Dr. Andersson opined that he would consider a traumatic event an injury if it caused something that influenced the degenerative changes or another type of injury. For instance, the traumatic event could cause changes that reflected a traumatic incident such as herniations or fractures. (RX 5, p. 22). However, Dr. Andersson testified that he reviewed the January 2012 [sic] MRI and that it did not reveal any herniations. As such, the surgery performed by Dr. Engelhard was to address spinal stenosis only, as there was no other reason to do it given findings on the MRI. (RX 5, p. 23-24).

With regard to the spinal stenosis, Dr. Andersson opined that it was not traumatically induced and was present in Petitioner before December 2007, and after December 2007. (RX 5, p. 24). Dr. Andersson again opined that after reviewing the MRI film, he believed that there were degenerative changes and stenosis at two levels. Dr. Andersson agreed that the central canal stenosis at L3–4 was moderate, which meant that it was not significant but also did not mean that Petitioner could not be symptomatic. (RX 5, p. 26). The doctor's opinion that the stenosis was not significant supported his opinion in that it suggested nothing traumatic happened in December 2007. (RX 5, p. 26-27). It was an important injury fact that there was no evidence of any traumatic changes on the [January 2008] MRI. (RX 5, p. 27), in light of the doctor's opinion that the diagnoses were an ongoing process and that the underlying degenerative condition and stenosis were developmental problems had been present for a long time prior to the alleged date of accident. (RX 5, p. 29-30).

When asked, Dr. Andersson again testified that he based his opinion that there was no accident in December 2007 based on the fact that Petitioner did not describe a traumatic accident and based on the fact that there was no evidence of any traumatic changes to the spine on the initial MRI in January 2008. (RX 5, p. 30).

Over Respondent's continued objections to the line of questioning, Dr. Andersson testified with regard to Dr. Paxton's initial record in January 2008. Petitioner's history in that record, that he thought his injury was from work, strongly suggested that there was no accident because otherwise Petitioner would specifically define that there was an accident. (RX 5, p. 36). Petitioner's later descriptions of the accident did not correspond with the initial treatment records. (RX 5, p. 37).

The doctor was then asked regarding the lack of accidental findings in the January 2008 MRI. To that end, the doctor testified the he would expect to see herniations, or significant compression of nerve tissue, or fracture, of which there were not. (RX 5, p. 43). Dr. Andersson also opined that the alleged accident would not have aggravated the degenerative conditions as there was no evidence that that happened, and the doctor did not believe that that actually happened typically. (RX 5, p. 43-44).

Dr. Andersson testified that he knew petitioner was addicted to narcotics the fact that he been on narcotic medication prolonged period of time and that creates an addiction. Doctor testified that was a 100% rule. (RX 5, p. 65).

On re-direct examination, Dr. Andersson testified and clarified that: (i.) assuming there was an accident, Petitioner had recovered by April 2009; (ii.) his opinion that there was no accident was based on the subjective reporting of Petitioner as it at his initial medical visits; (iii); if there was an accident, as reported later by Petitioner, it did not cause, aggravate, or accelerate any injuries as his spinal condition was degenerative in nature; (iv.) Petitioner was addicted to medication and if he did not take part in a weaning program, it would support that opinion; (vi.) Petitioner took and passed a DOT physical in April 2009 and was returned to work, which would support his opinion that he reached maximum medical improvement for any injuries, work-related or not, in April 2009. (RX 5, p. 66-68).

(iv.) Testimony of Eric Ahonen (PX 25)

September 17, 2013 Trial Testimony *(Serzynski v. Waukegan Roofing Company, Inc.; 12 L 125)*

Mr. Ahonen, Petitioner's son-in-law, testified with regard to the above-mentioned claim on September 17, 2013. The transcript of Mr. Ahonen's testimony was admitted into evidence by agreement of the parties as Petitioner's Exhibit 25 (PX 25), so to not require him to present before the Arbitrator and give the same testimony.

On direct examination, Mr. Ahonen testified that nothing stood out regarding Petitioner's medical history prior to December 27, 2007. He described Petitioner as being active and doing a lot of work around the house. (PX 25, p. 3). Mr. Ahonen did not recall any complaints of pain. Otherwise, Mr. Ahonen saw Petitioner sometime after December 27, 2007, on or about December 29, 2007. Mr. Ahonen Testified that Petitioner looked like he was in a bit of pain. Petitioner was holding his low back while he was in the kitchen, leaning over-the-counter. Petitioner shifted between sitting and standing quite frequently and looked uncomfortable. (PX 25, p. 4).

Subsequent to December 29, 2007, Mr. Ahonen testified that he would stop by to see how Petitioner was doing. (PX 25, pp. 7-8). Mr. Ahonen testified that he noticed Petitioner becoming progressively worse. Petitioner went from just leaning over-the-counter to lying on the couch rest of the day when he would be over there. Mr. Ahonen witnessed Petitioner crawl up the stairs one time because he was unable to stand up right and walk within normal pattern up the stairs. Mr. Ahonen did not see Petitioner take any medication. (PX 25, p. 8).

On January 7, 2008, Mr. Ahonen testified that Petitioner called him to come over because he was debating whether or not he needed to be taken to the emergency room. Upon arriving, Petitioner was lying on the couch in the family room complaining about pain. (PX 25, p. 10). Mr. Ahonen helped Petitioner off the couch and assisted him to his car so that he could drive him to the emergency room. (PX 25, p. 11).

Mr. Ahonen took Petitioner to Vista east in Waukegan. Mr. Ahonen that by the Petitioner's condition was poor when they got to the emergency room. Petitioner was in a lot of pain and was having difficulty standing and holding back while walking. (PX 25, p. 12). Mr. Ahonen testified that he did not see Petitioner take any medication prior to going to the hospital. He did not see Petitioner take any medication at the hospital. Mr. Ahonen did not see what was done for Petitioner at the hospital. (PX 25, p. 13). Mr. Ahonen did not see Petitioner after he was taken back from the waiting area to the emergency room until the following day. (PX 25, p. 13).

Mr. Ahonen went to see Petitioner the following day and testified that he was the same as he was previously, lying down and did not really get out of bed much. Over the next several days, Mr. Ahonen testified that Petitioner did not get any better nor did he get any worse. (PX 25, p. 14-15). Otherwise, Mr. Ahonen testified that Petitioner was slower moving overall and guarded with tasks. . (PX 25, p. 15-16).

(v.) Testimony of Dr. Susan Zuckerman (RX 2)

August 19, 2014 Evidence Deposition

Dr. Susan Zuckerman was deposed on August 19, 2014 with respect to the report that was prepared on July 2, 2014, at the request of Respondent and in accordance with Section 8.7 of the Illinois Workers' Compensation Act. Dr. Zuckerman testified that she is a Physical Medicine and Rehabilitation Physician certified by the

American Board of Physical Medicine and Rehabilitation and American Board of Electrodiagnostic Medicine in the State of Illinois. (RX 2, p. 5). When asked what a utilization review was, the doctor testified that it would be requested when there was a question about whether services such as procedures, testing, or medications prescribed for a patient were appropriate or necessary according to the Official Disability Guidelines. Utilization reviews do not address medical causal connection. (RX 2, p. 6).

Dr. Zuckerman testified that she performed a utilization review, with regard to Petitioner, as to the medical necessity of certain medications that were prescribed. (RX 2, p. 9). Once the case is assigned, there is a utilization review nurse who begins work on the case. That work is then sent to her by e-mail and she reviews all medical records that were available as well as the summary statement from the utilization review nurse She would then make a determination. In this particular case, the referral was made to her by Rising Medical Solutions. (RX 2, p. 10-11).

The first page of the report (RX 2, ex. 2), indicates that it was sent to Dr. Christopher Morgan. Dr. Zuckerman never heard from Dr. Morgan regarding any appeals of her findings. Otherwise, Dr. Zuckerman reviewed the medical records from Dr. Morgan. (RX 2, p. 12-13). She then testified to the approval, modification, or denial of certain treatment and services as detailed both in her deposition testimony (RX 2) and in the report (RX 2, ex. 2).

Otherwise, on cross-examination, Dr. Zuckerman testified that she did not know how the report was prepared, though she did review the summary. (RX 2, p. 31). In order to respond to questions about whether pain medications are necessary, she would need to see information regarding pain levels, functional status, adherence, and side effects. She did not see the documentation in the progress notes that were reviewed. (RX 2, p. 38).

On cross-examination, the doctor testified that if the evidence reflected that the medical records of Dr. Morgan were the same that she reviewed in preparation of the utilization review, then she would be satisfied with contents and results of the review. (RX 2, p. 44).

(vi.) Testimony of Dr. Michael Skaredoff (RX 3)

August 27, 2014 Evidence Deposition

Dr. Michael Skaredoff was deposed on August 27, 2014 with respect to the report that was prepared on July 1, 2014 (RX 3, ex. 2), at the request of Respondent and in accordance with Section 8.7 of the Illinois Workers' Compensation Act. Dr. Skaredoff, a Board Certified Anesthesiologist, and certified by the American Board of Anesthesiology with a subspecialty in pain management, in Illinois and other states, (RX 3, p. 5), testified that performs utilization reviews (RX 3, p. 5). To that end, he reviews a case to see whether or not a request is justified or not for treatment or service. In Illinois, a national set of guidelines call the Occupational Disability Guidelines, or "ODG Guidelines" are used. (RX 3, p. 8). Further, utilization reviews also come in to play when reviewing treatment that has already been rendered, but always address the reasonableness and necessity of treatment. (RX 3, p. 9).

With regard to this case, the doctor reviewed treatment that was rendered by Dr. Neeraj Jain. (RX 3, p. 10). After the doctor prepared and sent his report, he never heard from Dr. Jain. (RX 3, p. 13). Dr. Skaredoff agreed that the answers to the questions posed of him were based on the Occupational Disability Guidelines and based on a reasonable degree of medical certainty. (RX 3, p. 14). Dr. Skaredoff then testified to the approval,

modification, or denial of certain treatment and services as detailed both in his deposition testimony (RX 3) and in the report (RX 3, ex. 1).

Otherwise, on cross examination, Dr. Skaredoff testified that his practice involves both pain management assignments and classical anesthesiologist assignments. (RX 3, p. 36). With regard to preparation of utilization review on this case, the doctor was paid $55.00. (RX 3, p. 38). Dr. Skaredoff was asked if any of the notes of Dr. Jain "were sloppy." Dr. Skaredoff responded and opined that the notes were deficient and was exactly why everything was noncertified. The notes were deficient in justifying epidural steroid injections, in justifying medial branch in her blocks, and continuing with a number of Schedule II, Schedule III, and Schedule IV medications. There was no documentation pointing to the justification of said actions. (RX 3, p. 44). Further, Dr. Skaredoff testified that he reviewed not only the records of Dr. Jain but also those of Dr. Louis and Dr. Vargas [Dr. Jain's partners at Chicago Pain & Orthopedics). (RX 3, p. 45).

With regard to how he received the file, Rising Medical Solutions are the insurers who did the payouts, and Network Medical Reviews is the company that Dr. Skaredoff worked for which analyzes the files and records. (RX 3, p. 48). Rising sends Network Medical Review the file and then Network Medical Review chooses a given person who is most suited to look at the file, and in this case was Dr. Skaredoff. (RX 3, p. 49).

Dr. Skaredoff testified that his job was to make sure that the questions asked were congruent with the Guidelines set out by ODG. (RX 3, p. 52).

On re-direct, Dr. Skaredoff clarified that he reviewed the progress notes from Dr. Louis dated August 27, 2012 through October 30, 2012; the records of Dr. Jain dated December 6, 2011 through April 2, 2013; and the records of Dr. Vargas dated July 10, 2013 through January 8, 2014. The doctor also reviewed the lab notes from Chematox Laboratory dated March 5, 2013. He also reviewed the medical bills dated October 2, 2012 through January 12, 2014. (RX 3, p. 63).

(vii.) Testimony of Dr. Michael Musacchio (RX 4)

September 8, 2014 Evidence Deposition

Dr. Michael Musacchio was deposed on September 8, 2014 with respect to the report that was prepared on July 8, 2014, at the request of Respondent and in accordance with Section 8.7 of the Illinois Workers' Compensation Act. Dr. Musacchio, a neurosurgeon, board-certified by the American Board of Neurologic Surgeons and United States Licensing Exam in the state of Illinois, described a utilization review as taking clinical data that is submitted in trying to apply that to known guidelines that will be relevant to the condition being evaluated and assigning or trying to determine if the clinical data met requirements as dictated by the Official Disability Guidelines for approval or certification, versus non-certification, for given treatment process. (RX 4, p. 4-5).

With regard to this case, the doctor performed a utilization review as to the medical necessity of treatment rendered by Dr. Mark Lorenz. The third-party utilization review company, Nexus, e-mailed a request to the doctor to review this case. The e-mail contained two attachments: the first being a packet of clinical information, or progress notes and a surgical note, and the second being a draft of a utilization review report. Said report was that attached to the deposition as exhibit number two, as the doctor made no amendments as the guidelines were applied and followed correctly. (RX 4, p. 8-9).

Dr. Musacchio at no time spoke with or heard from Dr. Lorenz regarding the report and its findings. (RX 4, p. 10). The doctor testified as to the medical records that he reviewed, and the approval, modification, or denial of certain treatment and services as detailed both in his deposition testimony (RX 4) and in the report (RX 4, ex. 2).

On cross-examination, the doctor testified that he does do surgeries but no longer does utilization reviews. (RX 4, p. 39-40). He testified that he does not do utilization reviews anymore because it takes a lot of time and provides little clinical value to him. The doctor testified that it was a frustrating field because there is the reality of treating patients and what they know and think is good practice, and then there is trying to apply documentation. He just did not enjoy the work. (RX 4, p. 40).

Dr. Musacchio testified that he reviewed the report and served as a physician advisor such that he basically read it and cross-referenced the clinical documentation and agreed in totality with the report. (RX 4, p. 47).

(viii.) Testimony of Samantha Allen, MA, CRC, LPC (RX 9)

July 2, 2015 Evidence Deposition

Samantha Allen, MA, CRC, LPC, was deposed on July 2, 2015. Ms. Allen is a vocational rehabilitation counselor employed with Encore Unlimited who earned a master's degree in communicative disorders with an emphasis in vocational rehabilitation counseling, from Northern Illinois University in 2006. (RX 9, p. 5-6). She has been a Certified Rehabilitation Counselor since 2006 and had her certification renewed in 2011. (RX 9, p. 6-7). At the request of Respondent, Ms. Allen prepared two labor market surveys with respect Petitioner on March 19, 2015: one based on Petitioner's December 10, 2008 FCE (and noted physical restrictions), and the other based on Petitioner's November 19, 2013 FCE (and noted physical restrictions). (RX 9, p. 7, p. 14, p. 23; RX 9 ex. 1; RX 9, ex. 2). Ms. Allen explained that labor market surveys provide information on occupations or jobs that are available in an individual's labor market area, which would be a 50 mile radius of their home, and would include jobs appropriate for Petitioner's educational level, background, and work experience. (RX 9, p. 10). The labor market surveys included actual employers that were hiring at the time that the reports were prepared. (RX 9, p. 10). Ms. Allen prepared all relevant information regarding Petitioner's restrictions, background, work history, education, and then researched potential jobs, being sure to cross-reference the potential jobs against the Dictionary of Occupational Titles to ensure that any possible job would be within Petitioner's restrictions. (RX 9, p. 11).

Ms. Allen testified that she used the restrictions from Petitioner's December 10, 2008 Functional Capacity Evaluation (FCE hereafter) and also reviewed a vocational assessment that had been prepared by a different company. (RX 9, p. 12). It was Ms. Allen's understanding that Petitioner had a high school diploma and a commercial driver's license. (RX 9, p. 12). Ms. Allen testified as to her knowledge of Petitioner's prior work experience and the vocational goals that would be appropriate for Petitioner. (RX 9, p. 13). Based upon Petitioner's first FCE from December 10, 2008, Ms. Allen reviewed appropriate vocational goals, such as a cashier or truck driver, and determined which ones would fit within his restrictions and which jobs would be too strenuous for Petitioner to perform; she determined that, for all of the appropriate vocational goals, Petitioner would be able to be perform those jobs within his restrictions. (RX 9, p. 14-15). Ms. Allen also testified that Petitioner would be qualified for all of the types of work that he was interested in, though they might be entry level positions. (RX 9, p. 15). Ms. Allen testified that Petitioner should be able to obtain employment within his restrictions. (RX 9, p. 16).

Ms. Allen testified that she found actual jobs openings that Petitioner was capable of performing at the time of her investigation, including positions with No. 2, Metals USA, MV Transportation, Terminex, Chem Wise, Express Employment, Weber Packaging, and RockTenn. (RX 9, p. 16-20). These job openings ranged in pay from $12.00 per hour to $24.04 per hour. (RX 9, p. 19). Ms. Allen also recommended that Petitioner participate in a beginner computer class. (RX 9, p. 22).

Ms. Allen also reviewed Petitioner's second FCE from November 19, 2013 for her second labor market survey and determined that appropriate vocational goals for Petitioner were as follows: assembler; production; material inspector; gate guard; surveillance systems monitor; cashier; salesperson; customer service clerk; greeter; telephone solicitor; and assembler, semi conductor. (RX 9, p. 24). Ms. Allen testified that, based upon the second FCE from 2013, the Petitioner could still obtain a new position within those restrictions. (RX 9, p. 24-25). Ms. Allen identified 12 specific job openings that Petitioner could qualify for and perform with his restrictions from his 2013 FCE. (RX 9, p. 25-26; RX 9, ex. 2, p. 2-5). The employers for these jobs were hiring at the time of her labor market survey and the jobs ranged in pay from $10 to $15; all of these available jobs were within 50 miles of Petitioner's home. (RX 9, p. 25-26).

On cross examination, Ms. Allen testified that she never spoke with Petitioner and that her information was gained only from the FCE reports and a vocational assessment from another company. (RX 9, p. 28-29). Ms. Allen testified that she was not aware of whether Petitioner was receiving Social Security Disability benefits and that, if Petitioner was, that it would only create a barrier to Petitioner returning to work in that he would lose that income from the Social Security disability if he did obtain employment. (RX 9, p. 30). Ms. Allen testified that Petitioner could work in the jobs she found in a capacity that would be eight hours a day, five days a week, or 40 hours a week. (RX 9, p. 30). Ms. Allen's opinion that Petitioner could work full time was based upon the findings from one of Petitioner's FCE reports. (RX 9, p. 31). In reaching her opinions, Ms. Allen took into consideration the skill that Petitioner may have learned from his prior employment, regardless of when he had his past jobs, but she did not take his age at the time of the labor market surveys into consideration, as she did not believe that it was relevant. (RX 9, p. 32-33).

Ms. Allen further testified in cross examination that she took into consideration the fact that Petitioner could only perform certain activities occasionally, stating, "So if he is at lifting occasionally 20 pounds, occasional power lift 20 pounds, he is at occasional shoulder lift 15 pounds. So like, for example, I'm going to take the first job example for a computer assembler. He wouldn't be lifting a computer. He's be working with small parts building the keyboards, build things for the computer. So in that instance he might not ever have to lift 20 pounds on that particular job." (RX 9, p. 36-38). The job openings that Ms. Allen found for Petitioner allowed for sitting throughout the day. (RX 9, p. 38) Ms. Allen conceded that she did not have any basis to determine whether Petitioner could learn basic computer skills. (RX 9, p. 43).

Ms. Allen's second report, based on the 2013 FCE, included vocational goals that were only light duty and sedentary duty. (RX 9, p. 47; RX 9, ex. 2, p. 1) As part of her job, Ms. Allen refers to the Dictionary of Occupational Titles (DOT). (RX 9, p. 48). Ms. Allen never made a determination of what type of jobs Petitioner was interested in. (RX 9, p. 50). Ms. Allen did not specifically make a determination that Petitioner was able to "understand and carry out detailed, uninvolved written or oral instructions. Deal with problems involving a few concrete variables in or from standard situations." (RX 9, p. 50-51). Nor did Ms. Allen make a determination of whether Petitioner had "certain mathematical developments" or a determination that Petitioner could recognize the meaning of 2,500 two or three syllable words. (RX 9, p. 51). Ms. Allen did not assign SVP numbers to the potential jobs she found for Petitioner, but she did testify that the jobs she found did not require a lot of training or skill to begin with. (RX 9, p. 52). For the vocational goals that Ms. Allen testified were appropriate for

Petitioner, she only listed whether they were light or sedentary. (RX 9, p. 54). Ms. Allen did not specifically do any vocational rehabilitation for Petitioner (RX 9, p. 56). Ms. Allen testified that Petitioner's job skills were: working with customers in the workforce, knowledge of transportation, and working with other employees, but she also testified that she had no idea what he skills he had at the time of the deposition. (RX 9, p. 57). Ms. Allen also testified that she did not know whether Petitioner could perform certain occupations. (RX 9, p. 58). Ms. Allen used resources such as the internet and CareerBuilder to find jobs that Petitioner could perform (RX 9, p. 59-60).

On re-direct, Ms. Allen testified that her findings regarding Petitioner's ability to find employment were consistent with Dr. Engelhard's opinion that Petitioner was "certainly capable of some kind of work within the functional capacity evaluation limitations." (RX 9, p. 61). None of the possible jobs required lifting over 50 pounds (RX 9, p. 61). Ms. Allen relied on her conversations with employers in her professional capacity and in order to create the labor market surveys (RX 9, p. 62). The potential jobs that Ms. Allen found were based upon both internet research and confirmations that consisted of calling employers, verifying the physical requirements of jobs and ensuring that these were within the restrictions from his two FCEs. (RX 9, p. 69-73). Ms. Allen also testified that she could identify the labor market for Petitioner without speaking with him, given that she was aware of his education, work experience, and restrictions from his FCEs. (RX 9, 73-73).

On re-cross, Ms. Allen testified that she was not aware of whether Petitioner had returned to work, and also that this fact did not change any of her opinions. (RX 9, p. 76-77). In the potential jobs that Ms. Allen found for Petitioner, none of them required lifting more than 20 pounds occasionally. (RX 9, p. 80-81).

(ix.) Surveillance Footage of Petitioner (and corresponding reports) (RX 10)

The surveillance investigation results obtained from GlobalOptions speaks for itself and are contained in the reports and video attached as Respondent's Exhibit 10 (RX 10). However, the Arbitrator notes the following:

- On October 28, 2014, Petitioner is filmed at his home during the morning hours walking and moving about normally, without the use of a cane or other assistive devices and moving about normally. However, after exiting his vehicle later that afternoon in the parking garage at Midwest Orthopedics at Rush for his independent medical examination with Dr. Andersson, Petitioner was using a cane and walking in a very slow manner.

- On April 18, 2015, Petitioner is filmed standing and walking fluidly and extensively, and moving about normally, without the use of a cane or other assistive devices. Further, Petitioner is filmed loading groceries, bending at the waist, leaning, and lifting. Again, Petitioner was not using a cane or assistive device during this day.

- On April 19, 2015, Petitioner is filmed unloading items from his van and carrying diapers and groceries and bags into a residence. He is also filmed carrying a child. Again, Petitioner was not using a cane or assistive device during this day.

Petitioner's testimony with regard to this footage is contained in the summary below (x.).

(x.) Testimony of Petitioner

July 21, 2015 Trial Testimony

Direct Examination

Petitioner testified that on the amended date of the alleged accident, December 27, 2007, he was doing a roofing job that involved filling a crane bucket with stone. (T. 9, 7/21/15). As of the 14th or 15th bucket, he pushed as hard as he could to get the bucket underneath the tail chute when his legs slipped from underneath him, causing him to fall to his knees. (T. 10-11). He then noticed pain in his back and right leg. Jack the crane operator asked him if he was okay. (T. 11).

Prior to the alleged accident Petitioner testified that he was in great health and had no physical problems at all. (T. 16). He had passed every DOT physical that he had ever taken. (T. 17). After the alleged accident, he called Neal Andersson, dispatcher for Respondent, and reported that he was injured. (T. 17-18).

Petitioner continued to perform his job duties after the alleged accident occurred, which involved going to Thelan Sand and Gravel, ordering stone, and taking it to Amberly Woods in Lake Forest throughout the day (T. 18-20). However, he noticed pain as he continued to work on the alleged date of accident, while completing his jobs. (T. 20-21). He had to use his cruise control while driving on the alleged date of accident due to pain. (T. 24). While driving home on the alleged date of accident, he had to pull over to sit for an hour and a half as he experienced difficulty driving. (T. 26).

At the end of the day, Petitioner testified that he parked his truck, got in his personal automobile and drove home. When he returned home, his wife and daughter walked him in the house. (T. 27-28). He could not climb the stairs at his home on the night of the alleged accident so he slept on a couch. He also had to crawl to use the restroom that night. (T. 27-28).

Petitioner then testified that went to work the next day, December 28, 2007, despite complaints of pain. (T. 29). He thereafter worked on December 30, 2007, putting a truck and trailer together (T. 32), and for four more days after New Year's Day. (T. 34).

Petitioner then testified that he went to the hospital on January 8, 2008 [sic], driven by his son-in-law. (T. 36). While at the hospital, he received a shot as he was in pain. (T. 37). He then went to see Dr. Paxton on the next day, January 9, 2008 [sic] (T. 38). On or around January, 12, 2008, he underwent an MRI, and Dr. Paxton recommended that he see Dr. Engelhard. (T. 39).

Petitioner further testified that he noticed pain in his groin and stomach between seeing Dr. Paxton and Dr. Engelhard, and had never had such pain in the past. (T. 40). For those complaints, Dr. Paxton referred Petitioner to Dr. Liesen. (T. 41). Dr. Liesen performed hernia surgery at Vista Medical Center on June 12, 2008. (T. 43).

Petitioner also testified that Dr. Engelhard referred Petitioner to Dr. Arber, who prescribed pain medications and administered injections. (T. 44). Dr. Engelhard also prescribed physical therapy at Vista Medical Center. (T. 45).

Petitioner testified that he underwent lower back surgery with Dr. Engelhard on October 2, 2008 at Vista Medical Center (T. 46). After the surgery, he continued to see Dr. Engelhard and eventually underwent a Functional Capacity Evaluation at Vista. (T. 47).

Petitioner testified that he, himself, did not think that he could drive in 2009 as he could not work the gas and break. (T. 50). Petitioner testified that he tried looking for a job, without success (T. 52), but that he returned to work for Respondent on or about April 21, 2009 though June 3, 2010 (T. 56-59). Subsequent to June 3, 2010, Petitioner testified that Dr. Adamson referred Petitioner to Dr. Strongin. (T. 63), but also that Dr. Adamson had told him to get in touch with Dr. Lorenz. (T. 64).

Petitioner testified that he saw Dr. Lorenz in September 2011 (T. 65), and also saw Dr. Morgan and Dr. Jain, pain specialists, who provided medication and injections. (T. 66-67). Petitioner testified that he also saw Dr. Louis and Dr. Axel Vargas for pain management. (T 67-68).

Petitioner testified that he underwent a fusion, performed by Dr. Lorenz, in April 2013. (T. 69). Otherwise, he had his pain medication prescriptions filled through IWP (T. 70), underwent physical therapy at Accelerated Rehab (T. 72), underwent home therapy, administered by Amedisys (T. 73), and sought treatment at Lake County Health. (T. 77).

Petitioner testified that he is currently under the care of a pain management doctor, Dr. Diaconescu, whom he sees every month and a half, and Dr. Lorenz, whom he sees every eight months. (T. 77-78). Otherwise, he is not currently working and still has pain in his lower back and numbness in the right leg. (T. 79).

Petitioner testified that he is also receiving Social Security and is on Medicare. (T. 80).

Petitioner testified that he could not be a welder, a security guard, an assembler, a packer a telephone operator, a limousine driver, a dispatcher. (T. 81-85).

Cross-Examination

Petitioner testified that the crane operator whom he worked with on the alleged date of accident worked for Waukegan Roofing Company. Petitioner did not know his last name. Neal Andersson, dispatcher for Respondent, to whom he reported his alleged injuries, died in 2010. (T. 87).

When asked about the contents of the certified medical records of Vista Medical Center, which indicated that his chief complaint was leg pain with no known injury and dated January 7, 2008, Petitioner testified that said record was falsified. (T. 88-89).

When asked about the contents of the certified medical records of Dr. Paxton, which indicated that he did not have any specific injury or incident that precipitated the symptoms and dated January 8, 2008, Petitioner testified that it was also falsified. (T. 90).

Petitioner also testified that he denied reporting to Dr. Paxton on January 8, 2008 that he had back pain in the past, despite the contents of the certified records. (T. 92). However, Petitioner testified that Dr. Paxton did perform an examination of the abdomen on January 8, 2008, consistent with the certified records. (T. 92). Otherwise, Petitioner could not answer when asked if Dr. Paxton's January 8, 2008 record reflected that there was nothing out of the ordinary or unusual with regard to the examination of the abdomen. (T. 92-93).

Petitioner also testified that it was possible that the physicians at Vista Medical Center performed an examination of the abdomen as well on January 7, 2008, which would be consistent with the certified records. (T. 93). Petitioner was not sure if his medical records revealed no complaints of groin or abdomen pain until May 2008. (T. 101).

Petitioner testified that he took and passed a DOT physical in April 2009 and received a one-year card, when he returned to work for Respondent, but was incarcerated as of April 28, 2009 after being charged with domestic battery, a criminal felony. Petitioner testified that the charges were dropped. (T. 94-96).

Petitioner testified that he did not seek treatment between April 7, 2009 through July 17, 2010, aside from one visit to Dr. Paxton in October 2009. (T. 100-101).

Petitioner testified that he did not think he could use a telephone to call potential customers, in the capacity of a new profession, as he merely was "not good on the telephone." (T. 97). He also testified that he was not interested in undergoing training to use a computer or to learn how to do other things. That "office work is not [his] thing." (T. 98).

Petitioner testified that on April 22, 2015 he was using a cane when he presented to the hearing site for trial. (T. 99).

October 21, 2015 Trial Testimony (limited only to the contents (surveillance) of Respondent's Exhibit 10)

Direct Examination

Petitioner testified that he was present with his attorney, and attorney for Respondent, to view surveillance videos, and that it was him that appeared in the videos (10/21/2015 T. 6). Regarding the contents of the video, Petitioner testified that he went to the grocery store on the dates of the surveillance videos to buy paper towels, toilet paper, baby food and laundry detergent. (T. 7). The heaviest item in the cart was the detergent, which weighed 9 pounds. (T. 8). Petitioner testified that he would put one item at a time in his truck, using both hands. He made sure that everything was waist high and threw it on the floor inside of the van. He never unloaded the items from the van as Pam, his girlfriend, unloaded the van (T. 9). Petitioner further testified that the rest of the groceries included baby food that was in plastic containers and put in more bags so to even them out. (T. 10).

Petitioner testified that, on the videos, he was also carrying his seven month old grandson who was 14 or 15 pounds. He had no problem carrying him as he picked the child up waist high and held him close to his body. (T. 11). He was also carrying a Starlight container was a quarter full with baby clothes. He also had two boxes of baby shoes and three empty boxes. Together, these items weighed 4.5 pounds. (T. 12-13).

Petitioner wore his back brace during the videos, which held his back in though makes his ribs uncomfortably sore (T. 13-14), and that he used his cane going to Rush Hospital because his ribs were killing him from having his back brace on too many times. He uses the cane about 30% of the time, and when he goes to places where he is unsure of how far he has to walk or is otherwise unfamiliar with. (T. 14-15).

Petitioner testified that he performs no landscaping at his home and that it is handled by a landscape company. (T. 15), but he was shown sweeping a five-by-foot area of tree debris, and walking in the video as the doctor's want him to "do walking." (T. 16).

Petitioner testified that he has a 31-pound weight restriction as far as lifting, and a restriction of walking 25 feet carrying 25 pounds. However, he was in pain during the video when walking with any weight in his hands. He tries to even weight out on both sides. (T. 18).

Further, during the time the videos were taken, Petitioner testified that he was on medication, as prescribed by Dr. Diaconescu (T. 22), including blood pressure medicine, an iron pill, a vitamin pill, Hydrochloricide, Morphine Sulfur, Norco, Gabapentin, and Ibuprofen. (T. 24). He otherwise has severe pain when the medication wears off between doses and can feel his bone graft with shocking pains when bending over. His hips also would start throbbing. (T. 26).

Cross Examination

Petitioner testified that he did not weigh the items (other than the child) that he was seen carrying in the videos. He was merely estimating their weights (T. 31-32), and that the 31-pound lifting restriction, and restriction of walking no more than 25 feet while carrying 25 pounds was given by physical therapy in September 2013. (T.33).

II. CONCLUSIONS OF LAW

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

An injury is compensable under the Illinois Workers' Compensation Act only if it arises out of and in the course of employment. Panagos v. Industrial Commission, 177 Ill. App.3d 12, 524 N.E.2d 1018 (1988). The burden is upon the party seeking an award to prove by the preponderance of the credible evidence the elements of his claim. Peoria County Nursing Home v. Industrial Commission, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). The burden is also upon the employee to prove that his or her injuries are causally related to the employment. New Guard v. Industrial Commission, 58 Ill.2d 164, 317 N.E.2d 524 (1974). Critical to the determination of the aforementioned is Petitioner's credibility.

In this matter, the Arbitrator finds that Petitioner failed to meet his burden of proof in establishing that an accident arose of out of and in the course of his employment by Respondent on December 27, 2007. In support of this finding, The Arbitrator finds that Petitioner failed to provide a consistent or credible history of when or how his alleged injury occurred. In support of this finding, the Arbitrator relies on both certified medical records that were entered into evidence at trial, as well as Petitioner's testimony and the testimony of Petitioner's son in law, Mr. Ahonen, a certified industrial rehabilitation therapist.

With regard to Petitioner's medical records and treatment history, Petitioner first sought medical treatment on January 7, 2008 at the Vista Medical Center. (RX 7). It is noted on the Intake Form at this facility, and throughout the treatment record as a whole, that Petitioner complained of leg pain, not back pain, and that there was ***"no known injury"*** (emphasis added). There is no record that Petitioner complained of any back pain at this initial treatment visit. It was also noted that Petitioner complained of "pain to the right leg starting last Thursday," which would have been January 3, 2008. There is no indication anywhere in this record that Petitioner was injured on December 27, 2007, or any other date for that matter, while working for Respondent (RX 7, p. 52, 57).

Both Petitioner and James Ahonen, his son in law, testified that Mr. Ahonen took Petitioner to the Emergency room at Vista on January 7, 2008. Mr. Ahonen is a certified industrial rehabilitation therapist, and described clearly and lucidly and in great detail the condition he found Petitioner in when he arrived at his house on January 7, 2008. However, Mr. Ahonen never testified that Petitioner told him how he had come to be in this condition, and the Arbitrator finds this omission troubling, especially because of the professional qualifications of Mr. Ahonen. It is difficult to believe that Mr. Ahonen would arrive at Petitioner's home to find him in such pain that he was literally crawling up the stairs of his home, yet did not ask him what had happened to him and then relate same to this court in his testimony.

Thereafter, Petitioner sought treatment on the very next day, January 8, 2008, with a different provider, Dr. Paxton, at a different facility. (RX 6). It was again noted in Dr. Paxton's records that Petitioner presented with right leg pain that started "last week." More importantly, Petitioner again reported that he ***"did not have any specific injury or incident that precipitated his symptoms"*** (emphasis added). (RX 6). This record is supportive and echoes Petitioner's history as he provided on January 7, 2008. In fact, it was not until January 24, 2008, when Petitioner saw Dr. Engelhard that Petitioner reported and/or described an accident that occurred at work. However, even then, Dr. Engelhard's records reflect a reported accident date of September 28, 2007. (PX 5). Otherwise, the alleged accident date is inconsistent throughout Petitioner's medical treatment. The initial alleged accident date of December 28, 2007 was reported by Petitioner to his physicians subsequent to January 24, 2008 through January 8, 2009. (RX 5). Thereafter, Petitioner then began using an accident date of December 27, 2007, and then amended the accident date at trial to comport with same. (04/21/2015 T. 5).

Although Petitioner denied this evidence at trial, and testified that his medical records were falsified (04/21/2015 T. 88-90), he otherwise testified in detail regarding the alleged accident. The Arbitrator finds that Petitioner's testimony is not sufficient to sustain his burden of proof, especially in light of the long-standing principle expressed in Shell Oil v. Industrial Comm'n, 2 Ill.2d 590, 602 (1954), where the Illinois Supreme Court held that contemporaneous medical records are more reliable than later testimony because "it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid." In further support of that position, the Arbitrator also notes the opinions of both Dr. Andersson (who opined that it is unusual that one would have a work-related accident and not describe to the first two physicians who examined him [Vista Medical Center and Dr. Paxton], and then suddenly described to the third [Dr. Engelhard] (RX 1, p. 34)), and Dr. Lorenz (who opined that "a physician always assumes that the patient will tell you the truth in regard to his symptoms and the origin of the symptoms and the activities that brought them on and his current state." (PX 26, p. 32)).

For these reasons, the Arbitrator finds that Petitioner did not sustain his burden of proof that he sustained an accidental injury which arose out of and in the course of his employment by Respondent on December 27, 2007. All other issues are moot and are not addressed herein.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VALERIE ESSEBO,

Petitioner,

vs. NO: 05 WC 9830

TYSON FRESH MEATS, INC.,

Respondent,

16IWCC0417

DECISION AND OPINION ON §19(h) AND §8(a) PETITION

This case comes before the Commission on Petitioner's §19(h) and §8(a) Petition, alleging a material increase in her disability resulting in additional permanent disability and claiming additional medical expenses following the previous arbitration hearing, which was held on December 2, 2009. A hearing on the current petition was held before Commissioner Gore on February 9, 2016, in Chicago, Illinois and a record was made. The Commission, having considered the entire record, finds that Petitioner has failed to prove that she is entitled to additional medical expenses or permanency benefits.

The Commission notes that in its previous decision, dated September 26, 2011, some modifications were made to the Arbitrator's decision but it was otherwise affirmed and adopted. Particularly, the Commission affirmed the finding that Petitioner was not credible regarding her alleged continuing symptoms, complaints, and disabilities. Following are some excerpts of the Arbitrator's decision that explain why Petitioner was found to be not credible:

> The Arbitrator notes that Petitioner slipped and fell in her bathtub in early May 2005. The medical records indicate that she began to complain of pain in her neck and mid-back at that time. While the abnormalities in Petitioner's low-back are related to the [10/11/04] accident, the Arbitrator finds that any neck or mid-back pathology does not relate to the [10/11/04] accident....

(Arb. Dec. at 7).

...

> The Arbitrator finds that Petitioner's complaint of extreme low-back pain radiating into her legs and limited range of motion, beginning with the [FCE] on [3/6/07]

and the Dr. Dunbar examination on [4/8/07], and extending until and through the time of her arbitration testimony, lacks credibility. While the Record indicates that Petitioner has discogenic abnormalities at L4-5 and L5-S1 according to the MRI scan of [9/8/05], as well as the discogram of [4/12/06], the Record rather consistently shows that Petitioner's complains [sic] have no credibility.

Petitioner has told each doctor since April 2007, and explained at arbitration, that she performs no activities in her life with the exception of basic hygiene. She explained that she performs no household chores and that her husband performs all of those chores. She has explained that she cannot sit or stand longer than fifteen minutes without profound and debilitating pain.

The findings in the [FCE] of [3/6/07], Dr. Dunbar on [4/8/07], Dr. Herba on [81/08 and 7/27/09], Dr. Bernstein on [5/4/09], the [FCE of 6/8/09], and Dr. [Egwele] on [11/5/09], are nearly unanimous. Petitioner exhibited excessive guarding and cog-wheel muscle response at each facility, which is non-physiologic and indicates a manipulated result. She complained of tenderness to even light touch, but no doctor ever noted that she exhibited any muscle spasm. She either refused to perform or substantially underperformed grip strength testing which she related to her low back when the low back has no involvement with grip strength.

Both of the functional capacity evaluators noted that Petitioner's behavior away from the testing facility was significantly different and more functional than she behaved during the testing. The therapist on [6/8/09], actually noted that Petitioner refused to push or pull an empty cart as part of the testing, but he observed her pulling a passenger door on her car closed with no significant deficit. Dr. Bernstein noted that Petitioner exhibited normal strength in heel/toe standing with full weight bearing but had no strength against hand resistance when seated. A therapist on [6/8/09] noted that Petitioner had no change in heart rate despite periodic complaints of significant increases in pain, which the therapist wrote was not physiologically possible.

The information in the medical records rather consistently shows that Petitioner has engaged in extreme and elaborate efforts to manipulate the results of her physical examination and testing toward a result that she perceives to support total disability. With the exception of her chiropractor at Milan Medical Group, none of the doctors since March 2007, have supported her behaviors or have found the level of her complaints to be credible or legitimate.

(Arb. Dec. at 8).

At the Arbitration hearing on December 2, 2009, Petitioner testified that she was still having pain every day from her injuries and that if she sits or walks more than 15 minutes she had a lot of pain. She had to change positions frequently. She was taking pain and depression medications. In terms of housework, her husband did almost everything. (See Rx2).

At the §19(h)/8(a) hearing on February 9, 2016, Petitioner claimed that her injury reoccurred and that her pain was "very strong" from her neck to the back. She claimed that she now felt "like pinching" and a "woo, woo" feeling in her hip. She has pain when she goes to the bathroom and sometimes feels it in her chest. The pain radiates to her legs but she claimed that now it was not the left leg but the right leg.

However, the Commission notes that Petitioner complained about bilateral leg pain at the previous Arbitration hearing and her post-surgical MRI on September 8, 2005, indicated that

Petitioner's pain was radiating down the right leg. Therefore, we find that Petitioner's right leg pain, if true, is not new as she claims.

Petitioner also testified that she now has problems wearing pants since her pain has returned and it is difficult to put on her shoes because she can't lean forward. Petitioner also claims that her husband helps her with activities that she can't do anymore. The Commission notes that this new testimony is similar to her claim at the previous hearing that her husband did almost everything.

The first medical record in evidence in support of Petitioner's §19(h)/8(a) petition is from Dr. Bajaj on February 1, 2013, when Petitioner complained of low back pain, left and right leg pain, neck pain, headache, and a history of back surgery in 2005. He prescribed Lidoderm patch and physical therapy. The therapy was performed at Cure Touch and the first record indicates that Petitioner had severe low back pain radiating to the left leg and limited range of motion with 7-8/10 pain that started in 2004 and was exacerbated for the last 2 weeks.

On February 12, 2013, Petitioner saw Dr. Bajaj for low back, neck, and right arm pain. Dr. Bajaj ordered an EMG, MRI, physical therapy, x-ray, and Lidoderm patch. The Commission notes that the EMG that was performed on February 12, 2013, was for the cervical spine and upper extremities but the Commission has already found, in its previous decision, that Petitioner's cervical condition is not related to her work injury.

Petitioner treated at Fernando Suarez Physical Therapy from July 1st to October 9, 2013 for lumbar pain with radiculopathy to the bilateral lower extremities. On July 16, 2013, Petitioner was seen by Dr. Bajaj for low back and right leg pain. A lower extremity EMG was performed that day which was consistent with lumbosacral radiculopathy more on the right.

Petitioner testified that she saw Dr. Herba at Michigan Avenue Medical Associates on August 1, 2008, which was prior to the Arbitration hearing, and that she didn't return to that facility until July 29, 2013, when she saw Dr. Albert. However, the previous Commission decision found that Dr. Herba had performed a final evaluation of Petitioner on July 27, 2009. The Arbitrator wrote that Dr. Herba reported that Petitioner "complained of extreme pain upon even the slightest elevation and straight leg raising with no notation of muscle spasm" and that Petitioner exhibited a "'significant exaggeration of discomfort, with intermittent burning, etc.,' but he noted that she did have bulges on the MRI scan of September 2005." (Arb. Dec. at 7).

The evidence shows that Petitioner did see Dr. Albert on July 29, 2013. Dr. Albert documented a history that since Petitioner was discharged she had been living in New York and that her "pain is essentially unchanged" but that "she feels the pain radiates into both of her legs more than they did before." Dr. Albert recommended a new MRI. The MRI was performed and showed: 1) residual/recurrent right herniation vs. granulation L5-S1, with underlying bulge narrowing the foramina, right worse than left – recommend contrast study; 2) L4-5 disc bulge narrowing the foramina, left worse than right; 3) bulging of L2-3 and L3-4 discs narrowing the foramina left worse than right; 4) mild spinal stenosis.

We note that Petitioner did not return to Dr. Albert so he did not provide a medical opinion as to whether this new MRI would represent a "material increase" in her condition or disability.

Petitioner continued treating with Dr. Bajaj and had additional therapy at Cure Touch from March 18 to June 3, 2014. She had another lumbar MRI on April 11, 2014, that showed: 1) bilateral laminectomies at L5-S1 disc space; 2) moderate-sized right paracentral herniation at L5-S1 encroaching on the right S1 nerve root, bulging material also extending into the right neural foramen at the L5-S1 disc space abutting the right exiting nerve root; 3) diffuse disc bulge at L4-5 disc space as well as left posterolateral disc herniation extending into the left neural foramen

encroaching on the left exiting nerve root. Degenerative facet joint disease on the left side with hypertrophy of the ligamentum flavum at the L4-5 disc space contributing to left lateral recess stenosis; 4) small left paracentral herniation at L3-4 disc space extending into the left lateral recess.

Petitioner saw a neurosurgeon, Dr. Weiss, on May 21, 2014. He wrote that Petitioner stated her pain worsened in the back and legs after her laminectomy. We note that this would have been prior to the Arbitration hearing. Dr. Weiss wrote that Petitioner "is completely debilitated by pain." Petitioner's motor examination was grossly 5/5 although Petitioner made very limited efforts due to pain. Her sensory exam was symmetric and reflexes were normal. He reviewed the April 11, 2014 MRI and noted that it demonstrated the previous laminectomy and some degenerative disease at L4-5 and L5-S1 with some thickened ligamentum flavum and most likely some foraminal stenosis. Dr. Weiss opined that in the absence of obvious gross instability including facet fluid or spondylolistheses, there is an approximately 50-65% chance of pain improvement with a fusion, but that it would be reasonable to try if all other options fail. Petitioner was to contact him if she wanted to discuss the surgery. Petitioner has not returned to Dr. Weiss.

On July 19, 2014, Dr. Bajaj completed a Multiple Impairment Questionnaire indicating that Petitioner had severe 9-10/10 low back and neck pain constantly and that she was incapable of even "low stress" work due to pain. Petitioner also underwent physical therapy at Cure Touch from February 25th through June 24, 2015.

To prevail on her §8(a) petition, Petitioner has the burden to prove that her continued medical treatment is causally related to her work injury and, for the §19(h) petition, that her disability has recurred or materially increased.

The Commission has previously found that Petitioner's complaints were not credible. Although she claims that her symptoms are worse and there are some post-Arbitration-hearing medical records that could be seen to support this, we note that Petitioner's current complaints are similar to those that were specifically found to be not credible at the previous hearing. Petitioner saw Dr. Albert at Michigan Avenue Medical on July 29, 2013, but she did not return to see her previous physician at that same practice, Dr. Herba, who had found, on July 27, 2009, that Petitioner exhibited significant exaggeration of discomfort. We also find it significant that Petitioner's new doctors, in New York, had not reviewed any of her prior medical records and they weren't aware of the multiple previous medical opinions regarding Petitioner's exaggeration and malingering. Nor were they aware of the previous Commission decision finding that Petitioner was not credible about her complaints. Therefore, we are skeptical about the causal connection or off-work opinions by these physicians because Petitioner was complaining about symptoms, which were already found to be not credible.

Petitioner has not submitted evidence that would cause us to find that her new complaints are any more credible than those at the previous hearing. For example, Petitioner did not undergo a new, valid functional capacity examination, which might support her subjective symptoms and disabilities. Nor did she have a physician review all of the records, perform an examination, and give a fully informed opinion regarding causation, her credibility, her disabilities, and whether her alleged disability had "materially increased."

Based on Petitioner's failure to rehabilitate her credibility and the evidence in the record, we find that Petitioner has failed to prove that her current condition of ill-being is causally related to her work injury and that her disability has materially increased. Petitioner's §19(h)/8(a) petition is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) and §8(a) is hereby denied.

DATED: JUN 17 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 5/25/16
49

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fred Harmon,
Petitioner,

vs.

No. 08 WC 37092
(consol. with 10 WC 35376)

Kane County Forest Preserve,
Respondent.

16IWCC0418

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

This is the first of two claims that were tried together. Petitioner testified that on 12/5/06 he was 68 and worked as a full time patrolman for Respondent. While driving a squad car on patrol on that date, his vehicle was rear ended and pushed off the road into a ditch. His head hit the metal screen behind the headrest and his computer came up in the air, grazing his jaw and right shoulder. His back, arm and neck hurt and he was bleeding from the top of his head.

Petitioner was taken by ambulance to Delnor Hospital where he complained of neck and low back pain. X-rays were taken and he was diagnosed with neck and low back strains. Petitioner was released to his primary doctor, Dr. Susan Hamada, who referred him to an orthopedic doctor, Dr. Allen Van. Petitioner saw Dr. Van on 12/12/06 complaining of back, leg and neck pain. Dr. Van kept him off work and ordered a lumbar MRI. Following an unrelated surgery on 1/11/07, Petitioner resumed treatment with Dr. Van on 1/23/07. On 2/7/07 Dr. Van released Petitioner to full duty work as an officer. Petitioner continued taking medications but had no treatment after 2/2/07 until 9/25/07, when he returned to Dr. Van with complaints of increasing neck and right shoulder pain. Following a course of unsuccessful conservative care including physical therapy, Petitioner underwent a neurological evaluation with Dr. Ronald Bukowy on 3/13/08, and was referred to neurosurgeon Dr. John Brayton.

On 4/1/08, Dr. Brayton performed a 2 level (C4-5, C5-6) cervical fusion. Thereafter, Petitioner developed complications including difficulty swallowing; he required a video esophagram and speech therapy. On 5/5/08 Dr. Brayton released him to restricted work. On 5/21/08, after Petitioner told Dr. Brayton that he felt great and had no pain or weakness, Dr. Brayton released him to return to full duty work. Petitioner did return to all functional activities, working without restrictions from May 2008 until his 2nd work accident on 8/23/08. Petitioner admitted his cervical surgery was successful and provided him with significant though not 100% relief of his neck pain.

Dr. Allen Van, M.D., testified at a 2/6/09 discovery deposition taken in Petitioner's civil lawsuit. The transcript of that deposition was offered into evidence without objection by any party. At his deposition, Dr. Van, a board certified orthopedic surgeon, testified that Petitioner completed a questionnaire and pain diagram in which his main symptom was, "Back and left leg problem," following a December 2006 car accident. Petitioner returned to see Dr. Van on 12/29/06, 1/23/07 and 2/2/07, with no neck complaints documented on those dates, contrary to Petitioner's testimony that he had reported these to Dr. Van. On 2/2/07, Dr. Van reported, "all his back pain and leg pain is essentially resolved. He has no complaints to speak of." Dr. Van released Petitioner to full duty work as of 2/5/07. Dr. Van saw Petitioner 7 months thereafter, on 9/25/07, at which time Petitioner complained of cervical neck discomfort and stiffness and right shoulder pain. Dr. Van reported that was, "a new complaint."

Dr. Van further testified that if Petitioner had made neck complaints to him on 12/29/06, his exam would have been different. He testified that, "disc herniations and radicular symptoms tend to be very acute... if you slip a disc, instantly you will know it, either up in the arm or in the leg." He opined it would be, "highly improbable," for Petitioner to have symptoms from the 12/6/06 accident first manifesting on 9/7/07; in between, Petitioner returned to full duty and anything he did at work or outside of work could have caused the neck pain of which he complained on 9/7/07.

Dr. John Brayton, M.D., testified via 8/28/14 evidence deposition. He was Petitioner's neurosurgeon, and first examined him on 3/27/08. Then, Petitioner presented with complaints of left-sided neck pain radiating to his shoulder and elbow, which Petitioner reported occurred after a 12/5/06 rear end car accident. Dr. Brayton testified that although Petitioner's initial treatment focused on his lumbar symptoms, notes from his therapy documented cervical and lumbar symptoms. Petitioner's 3/16/08 cervical MRI revealed large disc herniations at C4-5 and C5-6, which Dr. Brayton opined were causally related to the 12/5/06 accident. Dr. Brayton believed that Petitioner's condition evolved since the MVA, and his findings were the result of disc herniation. Dr. Brayton testified that Petitioner required surgery because of the severe compression of the spinal cord and impending paralysis.

Dr. Brayton testified that by 6/6/08, Petitioner reported marked improvement in his pain; his radiating symptoms and myopathy signs had resolved completely, and his dysphasia was improving. Dr. Brayton disagreed with Dr. Van regarding the significance of Petitioner's lack of cervical complaints or problems following his 12/6/06 MVA through his release by Dr. Van on 2/2/07, and even through September 2007.

The Commission finds the opinions of Dr. Van more credible than those of Dr. Brayton, regarding causation of Petitioner's herniated discs and treatment after 2/4/07. Dr. Brayton provided no treatment to Petitioner until more than one year after his accident, long after Dr. Van's unrestricted release of Petitioner to full duty work. Based on the records and testimony, the Commission finds that Petitioner's condition of ill-being subsequent to 2/4/07 is not causally related to his 12/5/06 accident. Following Petitioner's 12/5/06 emergency room discharge, he had almost no documented cervical complaints for the next two months until his full release from care. Thereafter, he had no cervical complaints or cervical treatment until September 2007. Dr. Van opined that if Petitioner's discs had been herniated in the 12/5/06 accident, his symptoms would have been immediately apparent, and would not have taken months to develop. Dr. Van reported that during his treatment between December 2006 and February 2007, Petitioner made no cervical complaints to him.

The Commission finds that Petitioner attained maximum medical improvement from this accident on 2/5/07, and that Petitioner is not entitled to medical expenses or temporary total disability benefits after this date. Based on the above, the Commission reduces the Arbitrator's award of permanent partial disability in this case, 08 WC 37092, to 2% loss of a person under §8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 4/14/15 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and Respondent shall pay Petitioner the sum of $607.37 per week, commencing December 6, 2006 through February 4, 2007, totaling 8-5/7 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified, and Respondent shall pay Petitioner the reasonable and necessary medical expenses related to his shoulder, cervical spine and lumbar spine injuries only through February 4, 2007, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $105,347.42 for medical benefits plus $12,779.90 for other benefits paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act, but only through and including February 4, 2007.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of permanency is modified, and Respondent shall pay Petitioner permanent partial disability benefits of $546.64 per week for a period of 10 weeks, as provided in §8(d)2 of the Act, because the injuries sustained caused a 2% loss of use of the person as a whole.

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

16IWCC0418

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: JUN 20 2016

o-04/27/16
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARMON, FRED
Employee/Petitioner

Case# **08WC037092**
10WC035376

KANE COUNTY FOREST PRESERVE
Employer/Respondent

16IWCC0418

On 4/14/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0560 WIEDNER & McAULIFFE LTD
MICHAEL F DOERRIES
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

1228 KINNALLY FLAHERTY KRENTZ & LOR
JOSEPH LORAN
2114 DEERPATH RD
AURORA, IL 60506

16IWCC0418

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

Fred Harmon,
Employee/Petitioner

v.

Kane County Forest Preserve,
Employer/Respondent

Case # **08** WC **37092**

Consolidated cases: **10 WC 35376**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **New Lenox** on **11/18/14**, in the city of **Ottawa** on **12/19/14** and the city of **New Lenox** on **2/6/15**, at which time proofs were closed. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/5/06**, 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 condition of ill-being through 8/23/08 ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$41,909.12**; the average weekly wage was **$911.06**.

On the date of accident, Petitioner was **68** 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 **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$12,799.90** for other benefits, for a total credit of **$12,779.90**. (See Arb.Ex.#1).

Respondent is entitled to a credit of **$105,347.42** under Section 8(j) of the Act. (See Arb.Ex.#1).

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $607.37 per week for 16 weeks, commencing 12/6/06 through 2/4/07 and from 4/1/08 through 5/21/08, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 12/6/06 through 8/23/08, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $105,347.42 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $546.64 per week for 75 weeks, because the injuries sustained caused the 15% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

4/7/15
Date

APR 14 2015

STATEMENT OF FACTS:

Petitioner, a 68 year old patrolman, was hired by Respondent in 2000, after undergoing a physical exam of his neck, shoulders and low back. The physical exam did not reveal any condition that would preclude him from working full time as a patrolman. Petitioner's job duties carried him through the forest preserves in Kane County where he issued tickets, made arrests and opened as well as closed parks. There are 15 to 20 gates that provide access to the parks, each with two arms that extend some 8 to 10 feet and weigh over 100 pounds. Petitioner would swing the arms to open or close the gate access.

Before December 5, 2006, Petitioner had never suffered an injury to his neck, left shoulder or right shoulder that required medical care. He recalled a minor vehicular accident in the 1970s necessitating an x-ray of his low back and one week of physical therapy. He did not seek any ongoing treatment to his low back over the next 30 years. Further, as of December 5, 2006, Petitioner was not taking any medication for his neck, left shoulder, right shoulder, or low back.

On December 5, 2006 (08 WC 37092), at approximately 8:00 p.m., Petitioner was traveling in a squad car at 20 to 25 miles per hour on a road with a posted speed limit of 45. He noted that he was searching for ATVs that were on a county golf course when he was rear-ended by a pickup truck, causing him to strike the back of his head against a metal screen, and a computer to strike his right shoulder. His body struck the steering wheel as well. His vehicle was pushed some 40 to 50 feet into a ditch. Petitioner was bleeding from the top of his head and had symptoms in his neck, back, and arm. Photographs depict considerable damage to the rear end of Petitioner's vehicle and the front of the pickup truck. (PX4).

Ambulance personnel arrived at the accident scene finding Petitioner complaining of low back pain and "seeing stars." (PX5). He was fitted with a cervical collar, yet complained of neck pain and discomfort while in the collar. (PX5). He complained of increasing stiffness in his neck during his transport to Delnor Community Hospital. Petitioner described the neck pain while in the collar as "unbelievable," and a 10 on a scale of 1 to 10, with 10 being the worst. Petitioner arrived at the hospital that evening and complained of neck and back pain. (PX12). He underwent x-ray studies of the cervical and lumbar spine and was diagnosed with a neck and low back strain. He was told to ice the neck and back, rest, avoid physical activity, and follow up with his PCP.

Petitioner followed up with primary care physician, Dr. Hamada, on December 7, 2006 at which time he underwent an exam of his neck and low back. He was thereupon referred to Dr. Van, an orthopedic surgeon, who conducted an initial exam on December 12, 2006. Petitioner had neck pain, but his primary complaints were to the back and leg. Dr. Van prescribed a Medrol DosePak and authorized Petitioner off of work. Dr. Van ordered a MRI of the lumbar spine following a December 29, 2006 exam. Petitioner underwent surgery for a non-work-related aneurysm on January 11, 2007 and was released to full duty on February 7, 2007. (PX6).

Petitioner resumed working full duty as directed. However, Petitioner continued to note persistent neck pain for which he took Advil and Tylenol every few hours through the course of his eight-hour shift. The medication provided little relief of his symptoms, which included stiffness in the neck and slight back pains.

Petitioner indicated that his neck symptoms gradually worsened beginning in June 2007. He resumed medical care with Dr. Van on September 25, 2007. Petitioner denied suffering any injury outside of work during these seven months following his return to work. In addition, he noted that he had never experienced neck symptoms before the rear-end accident of December 5, 2006. Dr. Van diagnosed Petitioner with cervical arthrosis and a soft tissue sprain, warranting oral anti-inflammatory medications and physical therapy.

Petitioner attended physical therapy on ten occasions from September 25 through December 27, 2007, and continued working full duty. (PX7). At the time of a March 11, 2008 exam with Dr. Van, Petitioner complained of neck and bilateral shoulder pain as well as symptoms radiating to the right upper extremity. Petitioner testified he had not experienced such symptoms before the rear-end accident.

Because of the unremitting cervical complaints and radiculation, Petitioner underwent an EMG/NCV study with Dr. Bukowy on March 14, 2008 and a MRI of the cervical spine on March 16, 2008. Dr. Bukowy referred Petitioner to Dr. Brayton, a neurosurgeon. (PX8).

Dr. Brayton examined Petitioner on March 27, 2008 noting that he had neck pain immediately after the rear-end collision of December 5, 2006 and that there was no record of any pre-existing complaints. The MRI scan showed a large disc herniation at C4-5 and C5-6, causing very severe compression of the spinal cord. (PX9). Dr. Brayton performed surgery, a cervical decompression with an interbody fusion with hardware, at these levels, on April 1, 2008. (PX12). Petitioner discontinued working that day.

Postoperatively, Petitioner had difficulty swallowing, undergoing a video esophagram and speech therapy. He remained inpatient through April 7, 2008 and was fed mostly soft foods because of his swallowing difficulties. (PX12). Petitioner's condition improved postoperatively and he was released to modified duty on May 5, 2008 – no physical altercations – and told to attend physical therapy. He underwent x-rays of the cervical spine on May 20, 2008. The following day, he contacted Dr. Brayton's office, noted that he felt great with no pain or numbness, and asked to be return to work. Petitioner was released to return to work full duty effective May 22, 2008, though physical therapy was recommended to improve his mobility, endurance and strength. (RAX1).

Petitioner resumed working regular duty on May 22, 2008 and began physical therapy the following day. He performed all his assigned employment tasks, taking Advil, Tylenol and Flexeril as needed over the next 12 weeks. He did not lose any time from work because of his neck condition during this 12 week period. He attended eight physical therapy sessions at West Physical Therapy from May 23 through July 10, 2008. During a June 6, 2008 exam, Dr. Brayton recorded mild residual right-sided posterior neck stiffness and complete resolution of radiculation complaints. He did not schedule Petitioner for any additional exams. (RAX2).

While Petitioner was able to perform his employment tasks during this 12 week period, he noted that he did not have the same strength that he had had before the rear-end accident of December 5, 2006, particularly in his arms and shoulders. While performing daily activities during the months of May, June and July, 2008, he noticed neck stiffness. He had no complaints of pain or numbness in the left extremity and no complaints in the right upper extremity. He continued working full duty through August 23, 2008, the date of the second accident. Petitioner noted that while his symptoms had improved with surgery, he was not at 100%, and quantified his symptoms at 4 or maybe a 5 on a scale of 1 to 10 during this period.

On August 23, 2008 (10 WC 35376), Petitioner attempted to pick up the arm of a gate weighing over 100 pounds when it struck him in the stomach, causing him to fall to the street. See decision for companion claim 10 WC 35376 for ensuing treatment history.

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 record shows that Petitioner exhibited no evidence of a condition of ill-being with respect to his cervical and/or lumbar spine at the time of his hire by Respondent in 2000. In addition, there is no evidence to suggest that he was symptomatic for any condition of ill-being with respect to the cervical or lumbar spine prior to the

accident on December 5, 2006. Instead, the record clearly shows that on the date of the accident Petitioner was involved in a serious motor vehicle accident when he was struck by another vehicle from behind. The record also supports Petitioner's claim that he complained of neck and low back pain at the scene of the accident as well as at the emergency room, where cervical x-rays were taken. Petitioner thereupon made similar neck and low back complaints to his primary care physician, Dr. Hamada, several days later. Given these facts, the Arbitrator finds Petitioner's testimony as to the nature of his injuries to be credible.

Dr. Brayton, Petitioner's treating neurosurgeon, rendered care for over six years from March 27, 2008, through October 13, 2014. He found no evidence of neck complaints or treatment for same before the December 5, 2006 work related motor vehicle accident, and no evidence of a non-work related event occurring after Petitioner returned to work on February 5, 2007. (PX26, pp.14,24). Dr. Brayton diagnosed Petitioner with severe radiculopathy from severe nerve root and spinal cord compression from large disc herniations and spondylitic changes at C4-5 and C5-6. (PX26, p.18). He concluded these disc herniations and changes were caused by the December 5, 2006 accident and progressed and caused severe spinal cord compression. (PX26, p.19). Further, Dr. Brayton opined that this work accident caused the need for surgery. He based this opinion on the history recorded by the ambulance personnel on December 5, 2006, the histories recorded in the emergency room later that day, and results of diagnostic studies. (PX26, p.22). He noted that the fact Dr. Van did not immediately record cervical complaints did not affect his opinion, as Petitioner was experiencing an evolving process of spinal cord compression. (PX26, p.23). Dr. Brayton indicated that he considered Petitioner extremely stoic and not inclined to voice complaints other than those that were the focus of an exam. Dr. Brayton also explained that the degenerative changes were minor compared to the degree of spinal cord compression. (PX26, p.23). In addition, Dr. Brayton noted that the degree of spondylitic changes in the cervical spine would not have caused the degree of compression had the December 5, 2006 vehicular accident not occurred. More to the point, Dr. Brayton believed that the disc herniations were the result of a traumatic injury.

Furthermore, Dr. Brayton noted minimal degenerative changes in the cervical region on x-rays performed shortly after the rear end accident compared to severe compression from spondylotic changes and large disc herniations at C3-4 and C4-5, which he felt were traumatically induced, on the MRI performed on March 16, 2008. In addition, there is no evidence of a non-work related incident occurring from the time Petitioner returned to full duty work on February 7, 2007 and his resumption of care with Dr. Van on September 25, 2007 that could reasonable explain these findings.

Dr. Van, Petitioner's primary care physician, testified in regards to the civil action brought following the December 5, 2006 motor vehicle accident. Dr. Van noted that he did not record complaints of neck pain until his fourth exam of September 25, 2007. (RAX7, p.20). He indicated that while he considered these new complaints which had gradually increased leading up to his September 25, 2007 exam, a cervical disc herniation can result from an abrupt force to the head and to the neck. (RAX7, p.33). Dr. Van also agreed that the ER records from December 5, 2006 reference a high-speed auto accident resulting in neck and low back complaints. (RAX7, p.34). He noted that he did not know of any trauma other than the rear-end accident of December 5, 2006 and that he did not examine Petitioner after March 11, 2008. (RAX7, pp.40,42). Dr. Van also agreed that an individual with asymptomatic cervical arthritis before a high-speed trauma could experience symptoms that get worse over a year and that eventually become a serious problem. (RAX7, p.43).

Based on the above, and the record taken as a whole, including the credible testimony of Petitioner, the Arbitrator finds that a causal relationship existed between the undisputed work accident on December 5, 2006 and Petitioner's ensuing cervical and lumbar spine conditions up through the date of the second accident on August 23, 2008, including large disc herniations at the C4-5 and C5-6 levels, eventually necessitating the

surgery performed on April 1, 2008. Along these lines, the Arbitrator relies upon the opinions of Dr. Brayton set forth above.

The Arbitrator further notes that Petitioner's condition of ill-being subsequent to the second accident on August 23, 2008 is the subject of companion claim 10 WC 35376.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner was temporarily totally disabled from December 6, 2006 through February 4, 2007, when he was released to full duty work by Dr. Van, and from April 1, 2008, the date of surgery, through May 21, 2008, the day before he returned to work full duty following said surgery, for a period of 16 weeks.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner sustained two large disc herniations at the C4-5 and C5-6 levels causing severe spinal cord and nerve root compression necessitating surgery – a cervical decompression with interbody fusion with hardware – on April 1, 2008. While his condition significantly improved so he was able to return to his regular job on May 21, 2008, he did not have the same strength he had before in his arms and shoulders that he had before the work injury. He also noticed neck stiffness while performing activities of daily living. Further, he took Tylenol and Advil to relieve his symptoms, which he quantified as a 4 to 5 on a scale of 1 to 10.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of a person-as-a-whole, pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the stipulation of the parties (see Arb.Ex.#1), the Arbitrator finds that Respondent shall be given a credit of $105,347.42 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. Further, Respondent shall be given credit for $12,779.00 for salary/group benefits paid under Section 8(j) of the Act. (Arb.Ex.#1).

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fred Harmon,
Petitioner,

vs.

No. 10 WC 35376
(consol. with 08 WC 37092)

Kane County Forest Preserve,
Respondent.

16IWCC0419

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 causal connection, medical expenses, temporary total disability, permanent disability and penalties and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Arbitrator's Decision, which is attached hereto and made a part hereof.

This is the second of this Petitioner's two claims that were tried together. On 8/23/08, while he was working his usual and customary duties as a full time forest district patrol officer, one of the forest preserve's 100 lb. gates he was closing came off and struck him in the stomach, knocking him down. He immediately felt pain in his neck, back and shoulder and was taken to Delnor Hospital for an exam and neck x-rays. He contacted Dr. Brayton and also neurosurgeon Dr. Johnson for a second opinion.

On 12/1/08, while still undergoing conservative treatment, Petitioner accepted an offer from Respondent to work a job as a "house attendant," a position which accommodated his restrictions. On 4/8/09, while working in that capacity, Petitioner had a conversation with his supervisor, Sergeant Bill Glisson. Petitioner's entire testimony regarding that conversation was:

Q. What did Sergeant Glisson say to you and what did you say to him?
A. He walked in and said, Harmon, you are no longer a policeman.
Q. Did you continue modified duty until April 8, 2009?
A. No. I walked out.

The following day, 4/9/09, Dr. Brayton performed cervical surgery, after which Petitioner required speech therapy and a temporary feeding tube. On 12/10/09, Dr. Brayton released him to light duty work with restrictions. At that time, he was taking prescription Norco.

On 5/11/11, Petitioner attended a vocational assessment with Joe Belmonte of Vocamotive, and provided him with his work history, which included working as a Chicago Police Officer for 29 years, earning a pilot's license and working as a charter pilot and an instructor. On 6/13/12, Petitioner met with Ed Rascati of EJR Consulting for a vocational evaluation at Respondent's request. Petitioner was offered vocational retraining by Respondent.

On 11/14/12, Petitioner saw Dr. Brayton with complaints of left shoulder pain, neck pain and left arm tremors. Then, Petitioner was taking Norco, Relafen, Lisinopril and Flexeril on a daily basis. Petitioner underwent a neurological evaluation with Dr. Kukowy on 11/20/12. On 12/21/12, Petitioner developed neck and left arm pain after he got up from a chair after playing video chess on his laptop computer. He sought immediate care at Delnor Hospital, where he was admitted and stayed for four days.

On 9/4/13, Petitioner again required treatment at Delnor Hospital after left shoulder and arm pain, which he had been experiencing for several days, became uncontrollable. He underwent a cervical fusion with Dr. Brayton on 9/10/13.

Since his 9/10/13 surgery, Petitioner testified he is able to drive, go to the store, run daily errands, and do yard work including cutting grass on a riding mower, pulling weeds, and using an electric hedger. On 1/9/09 Dr. Brayton allowed him to perform sedentary work on a full time basis, and on 3/11/10 Dr. Brayton told him he could do sedentary work with frequent breaks every 30 minutes. On 5/20/10, Dr. Brayton told Petitioner he had complete resolution of his C3-4 compression with no significant compression between C3-C7. On 12/17/10, Dr. Brayton told him he was at maximum medical improvement, as good as he was going to get, but he couldn't work. Following his December 2012 hospital release, Petitioner received no further treatment to his neck until 9/4/13. Petitioner admitted he has no restrictions for driving a car and he can often drive for 90 minutes.

Dr. John Brayton, M.D. testified via deposition that on 4/9/09 he performed an anterior cervical reexploration, removal of the hardware at C4-5 and C6-7, and decompression and fusion with plating at C3-4. By 12/10/09, Petitioner's spinal cord compression deficits completely resolved, his nerve root compression deficits improved dramatically and his swallowing difficulties improved significantly. While Petitioner met the criteria for light duty release based on his work conditioning evaluation, Dr. Brayton did not release him to work because he was still taking Norco and he believed Petitioner might have to use firearms or other dangerous weapons. Following Petitioner's 9/4/13 hospitalization, during which he complained of intolerable left arm symptoms of a few day's duration, Dr. Brayton performed a C3-7 posterior cervical decompression and lateral mass fusion because of progressive root compression. Dr. Brayton opined this surgery was causally related to Petitioner's work injuries.

On cross-examination, Dr. Brayton admitted that on 3/11/10 he released Petitioner to sedentary work with frequent breaks every 30 minutes. Petitioner's cervical osteoarthritis progressed from 2008 to 2013 without any additional trauma, and it was possible Petitioner's cervical problems in September 2013 were the result of his non-occupational cervical spondylosis. Dr. Brayton did not restrict Petitioner from driving, and admitted he has not restricted Petitioner from all sedentary employment. If he reassessed Petitioner, Dr. Brayton might find him able to work in a sedentary setting if he was not required to perform paperwork with his left arm and could take frequent breaks. He admitted that persons with degenerative disc disease can tear an annulus from any of a number of things, including coughing or sneezing. Dr. Brayton admitted that he could not state within a reasonable degree of medical and surgical certainty that Petitioner's 8/23/08 work accident was a factor in his need for 9/10/13 surgery, considering Petitioner's histories and medical records, the progressive nature of his cervical arthritis, and Dr. Brayton's previous 4/16/09 deposition testimony.

Joseph Belmonte, a certified rehabilitation counselor, met with Petitioner on 5/11/11 for a vocational assessment. Although he admitted there are sedentary jobs which don't involve paperwork, he testified Petitioner had no transferrable skills and could not perform gainful employment in any occupation. Ed Rascati, Respondent's certified vocational rehabilitation counselor, testified he met with Petitioner for an evaluation on 6/7/12. Rascati opined Petitioner had transferrable skills, could perform a variety of duties and was capable of employment in security work, dispatch and customer service.

Dr. Zelby, Respondent's expert, examined Petitioner on 3/14/12, finding he had a normal neurologic exam and his fusions were healed. Dr. Zelby gave the following opinions: Petitioner needed no further spine treatment irrespective of cause; he was at MMI; he easily qualified for light to medium duty work; his condition was a progression of the natural history of his degenerative condition; osteoarthritis is chronic and degenerative and can result in disc herniation and spur formation absent any identifiable trauma; and Petitioner's 8/23/08 incident did not cause his spondylosis, given that his pre- and post- 8/23/08 MRI's were unchanged. Petitioner's 9/10/13 surgery was for degenerative changes in the cervical spine, not caused by the 8/23/08 accident. The 9/10/13 surgery was not necessary as a result of the 8/23/08 accident. Petitioner himself ascribed his increased neck pain to playing on-line chess; it was clear that that's what brought him back to treatment.

The Commission agrees with the Arbitrator's finding that Petitioner's 8/23/08 work injury caused a C3-4 herniation, necessitating the 4/9/09 spinal surgery performed by Dr. Brayton.

However, the Commission finds that Petitioner reached MMI on 3/12/12, based on Dr. Zelby's opinions, which it finds more persuasive than those of Dr. Brayton on the issues of causation and return to work. Dr. Brayton admitted that Petitioner's cervical osteoarthritis progressed from 2008 to 2013 without any additional trauma and that Petitioner's cervical problems in September 2013 could possibly be the result of his non-occupational cervical spondylosis.

In finding Dr. Brayton's testimony less credible than Dr. Zelby's, the Commission finds that Dr. Brayton changed his answers, depending on which attorney was asking him questions. Dr. Brayton did not find Petitioner's intermittent use of narcotics significant enough to impose restrictions on operating a motor vehicle, yet he believed use of this medication made it unsafe for him to perform even sedentary work. Dr. Brayton's opinion on this issue appears based upon his inaccurate assumption that returning Petitioner to employment would jeopardize public safety in that Petitioner might be required to use firearms. In fact, Petitioner had not been working as a patrol officer but rather, as a house attendant, a fact of which Dr. Brayton appeared unaware. Dr. Brayton also underreported Petitioner's abilities. Petitioner testified he could drive a car for 90 minutes at a time, yet Dr. Brayton opined Petitioner could only sit for 30 minutes at a time.

The Commission finds Petitioner's December 2012 hospitalization following his chess playing incident was not causally related to his work accident; the need for that treatment and 4-day hospital stay arose suddenly following an intervening event. Similarly, Petitioner's need for his September 2013 neck surgery arose after symptoms which manifested only days before that, per Petitioner's own admission. Both Drs. Brayton and Zelby agreed that persons with degenerative disc disease could herniate a disc from a number of non-occupational activities such as coughing and sneezing.

The Commission finds Petitioner proved he is entitled to TTD only from 8/24/08 through 11/30/08, that date before he began working a modified duty job from Respondent, and from 4/9/09 through 12/10/09, the period between Petitioner's 4/9/09 causally related cervical surgery and the date of Dr. Brayton's exam at which that Petitioner found met the criteria for light duty release to work, which Respondent had been providing.

The Commission finds, based on Petitioner's 4/8/09 conversation with his supervisor, Glisson, that Petitioner's action of walking out after being reminded that he was no longer a policeman was tantamount to a voluntary termination on Petitioner's part and a refusal to work in a position Respondent had provided which accommodated his restrictions. Respondent was justified in terminating TTD benefits at that time. For over 4 months prior to that, Petitioner had been aware he was not working as a policeman. Petitioner testified he had accepted a job as a "house attendant" for Respondent in November 2008. The Commission cannot construe Glisson's re-statement of this fact to be an involuntary termination.

The Commission affirms the Arbitrator's award of TTD benefits for the period between Petitioner's 4/9/09 surgery and Dr. Brayton's 12/10/09 release to light duty; it was causally related, and Petitioner was temporarily totally disabled from working between those dates.

In rejecting Petitioner's argument that he is entitled to TTD through 5/23/12 because Respondent asserted that date on the Request for Hearing sheet (ArbX 2), the Commission finds that Respondent did not agree with or stipulate to the dates Petitioner claimed TTD was owed, and Petitioner did not agree with or stipulate to the dates which Respondent claimed TTD was owed. In the absence of an agreed stipulation, the Commission is not bound by a party's assertion, should the evidence establish a different conclusion as it does in this case. Rule 7030.40 does not preclude the Commission from such a finding.

The Commission finds Petitioner is neither a medical permanent total nor an odd-lot permanent total as a result of his 8/23/08 work accident, and reverses the Arbitrator's permanency award. Instead, the Commission finds Petitioner to be permanently and partially disabled to the extent of 40% loss of a person as a whole, under §8(d)2 of the Act. In so finding, the Commission relies on the fact that Petitioner was working an accommodated job at Respondent when he ceased working on 4/8/09; he has not looked for work since 12/10/09; Dr. Brayton released Petitioner to sedentary work outside of law enforcement with breaks every 30 minutes; Dr. Zelby found Petitioner able to work light to medium work; Ed Rascati opined there was a stable job market for sedentary work, which Petitioner could perform, and Petitioner admitted he could drive a car for up to 90 minutes, cut grass on a riding lawn mower, pull weeds, and use a hedge trimmer. The Commission finds Ed Rascati's opinions more persuasive than those of Joe Belmonte.

Finally, the Commission affirms and adopts the Arbitrator's finding that Petitioner is not entitled to penalties or attorney's fees under §16, §19(k) or §19 (l), because, "Respondent's conduct in the defense of this claim was neither unreasonable nor vexatious under the circumstances, given the multiple issues involved." The Commission finds that Respondent's termination of TTD benefits on 5/23/12 was clearly due to Dr. Zelby's opinions following his 3/14/12 examination, at which he found Petitioner capable of light to medium work. As noted, Respondent had been providing Petitioner with work within these restrictions until 4/8/09.

SPECIAL FINDINGS

In response to Respondent Kane County Forest Preserve's Request for Special Findings, the Commission states as follows:

1. Did Dr. Brayton release the Petitioner to full time sedentary employment that did not involve law enforcement on December 17, 2010?

   ANSWER: Yes.

2. Did the Petitioner testify on December 19, 2014 that he has not looked for a job since December 17, 2010?

   ANSWER: Yes.

3. Did Dr. Brayton release the Petitioner to full time light duty employment on December 10, 2009?

   ANSWER: Dr. Brayton stated that on that 12/10/09, Petitioner met the criteria for a light duty release to work; however, Dr. Brayton further stated he did not release Petitioner because he was taking prescription Norco.

4. Does the Illinois Appellate Court hold in *Sharwarko v. IWCC, 1-13-1733WC (1st Dist. 2015)* and *City of Granite City v. Industrial Commission, 279 Ill.App.3d 1087 (1996)* that when a Petitioner voluntarily retires and removes himself from the labor market the Petitioner is no longer entitled to temporary total disability benefits?

ANSWER: Those were the Appellate Court's holdings in those cases for the fact situations described in those cases.

5. With the exception of the chess playing exacerbation on December, 21, 2012, did the Petitioner have a gap in treatment for his cervical spine from December 17, 2010 until September 10, 2013?

ANSWER: No; the records contains evidence that Petitioner did receive treatment for symptoms likely related to his cervical spine, in addition to his treatment in December 2012 following his chess playing incident, between December 17, 2010 and September 10, 2013.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 4/14/15 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and Respondent shall pay Petitioner the sum of $634.57 per week, commencing August 24, 2008 through November 30, 2008 and from April 9, 2009 through December 10, 2009, totaling 49-2/7 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified, and Respondent shall pay Petitioner those reasonable and necessary medical expenses related to his cervical spine injuries that were incurred through his MMI date of March 12, 2012, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $107,296.41 for benefits that have been paid to or on behalf of Petitioner on account of said accidental injuries. Respondent shall hold Petitioner harmless only from any claims by any providers of the services for which Respondent is receiving this credit that have been incurred between August 23, 2008 and March 12, 2012, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of permanency is modified, and Respondent shall pay Petitioner permanent partial disability benefits of $571.12 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, because the injuries sustained caused a 40% loss of use of the person as a whole. Petitioner is not eligible for cost of living adjustments paid by the Rate Adjustment Fund pursuant to §8(g) of the Act, and the Arbitrator's award of such is reversed.

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

16IWCC0419

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $38,300.00. 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: JUN 20 2016

o-04/27/16
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARMON, FRED
Employee/Petitioner

Case# **10WC035376**
08WC037092

KANE COUNTY FOREST PRESERVE
Employer/Respondent

16IWCC0419

On 4/14/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0560 WIEDNER & McAULIFFE LTD
MICHAEL F DOERRIES
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

0075 POWER & CRONIN LTD
REL
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

16IWCC0419

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

Fred Harmon,
Employee/Petitioner

v.

Kane County Forest Preserve,
Employer/Respondent

Case # **10** WC **35376**

Consolidated cases: **08 WC 37092**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **New Lenox** on **11/18/14**, in the city of **Ottawa** on **12/19/14** and the city of **New Lenox** on **2/6/15**, at which time proofs were closed. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/23/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$49,496.72**; the average weekly wage was **$951.86**.

On the date of accident, Petitioner was **70** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$107,296.41** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$107,296.41**. (Arb.Ex.#2).

The parties agreed that Respondent is entitled to a credit for bills paid on account of this injury. (Arb.Ex.#2).

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $634.57 per week for 115 weeks, commencing 8/24/08 through 11/24/08, from 4/9/09 through 12/10/09 and from 9/10/13 through 12/19/14, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 8/24/08 through 2/6/15, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $107,296.41 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $40,707.36, 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 permanent and total disability benefits of $634.57 per week for life, commencing **12/20/14**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

Respondent shall pay to Petitioner penalties of **$0.00**, as provided in Section 16 of the Act; **$0.00**, as provided in Section 19(k) of the Act; and **$0.00**, as provided in Section 19(l) of the Act.

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

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

Signature of Arbitrator

4/7/15
Date

APR 14 2015

STATEMENT OF FACTS:

Petitioner, a 68 year old patrolman, was hired by Respondent in 2000, after undergoing a physical exam of his neck, shoulders and low back. The physical exam did not reveal any condition that would preclude him from working full time as a patrolman. Petitioner's job duties carried him through the forest preserves in Kane County where he issued tickets, made arrests and opened as well as closed parks. There are 15 to 20 gates that provide access to the parks, each with two arms that extend some 8 to 10 feet and weigh over 100 pounds. Petitioner would swing the arms to open or close the gate access.

Before December 5, 2006, Petitioner had never suffered an injury to his neck, left shoulder or right shoulder that required medical care. He recalled a minor vehicular accident in the 1970s necessitating an x-ray of his low back and one week of physical therapy. He did not seek any ongoing treatment to his low back over the next 30 years. Further, as of December 5, 2006, Petitioner was not taking any medication for his neck, left shoulder, right shoulder, or low back.

On December 5, 2006 (08 WC 37092), at approximately 8:00 p.m., Petitioner was traveling in a squad car at 20 to 25 miles per hour on a road with a posted speed limit of 45. He noted that he was searching for ATVs that were on a county golf course when he was rear-ended by a pickup truck, causing him to strike the back of his head against a metal screen, and a computer to strike his right shoulder. His body struck the steering wheel as well. His vehicle was pushed some 40 to 50 feet into a ditch. Petitioner was bleeding from the top of his head and had symptoms in his neck, back, and arm. Photographs depict considerable damage to the rear end of Petitioner's vehicle and the front of the pickup truck. (PX4).

Ambulance personnel arrived at the accident scene finding Petitioner complaining of low back pain and "seeing stars." (PX5). He was fitted with a cervical collar, yet complained of neck pain and discomfort while in the collar. (PX5). He complained of increasing stiffness in his neck during his transport to Delnor Community Hospital. Petitioner described the neck pain while in the collar as "unbelievable," and a 10 on a scale of 1 to 10, with 10 being the worst. Petitioner arrived at the hospital that evening and complained of neck and back pain. (PX12). He underwent x-ray studies of the cervical and lumbar spine and was diagnosed with a neck and low back strain. He was told to ice the neck and back, rest, avoid physical activity, and follow up with his PCP.

Petitioner followed up with primary care physician, Dr. Hamada, on December 7, 2006 at which time he underwent an exam of his neck and low back. He was thereupon referred to Dr. Van, an orthopedic surgeon, who conducted an initial exam on December 12, 2006. Petitioner had neck pain, but his primary complaints were to the back and leg. Dr. Van prescribed a Medrol DosePak and authorized Petitioner off of work. Dr. Van ordered a MRI of the lumbar spine following a December 29, 2006 exam. Petitioner underwent surgery for a non-work-related aneurysm on January 11, 2007 and was released to full duty on February 7, 2007. (PX6).

Petitioner resumed working full duty as directed. However, Petitioner continued to note persistent neck pain for which he took Advil and Tylenol every few hours through the course of his eight-hour shift. The medication provided little relief of his symptoms, which included stiffness in the neck and slight back pains.

Petitioner indicated that his neck symptoms gradually worsened beginning in June 2007. He resumed medical care with Dr. Van on September 25, 2007. Petitioner denied suffering any injury outside of work during these seven months following his return to work. In addition, he noted that he had never experienced neck symptoms before the rear-end accident of December 5, 2006. Dr. Van diagnosed Petitioner with cervical arthrosis and a soft tissue sprain, warranting oral anti-inflammatory medications and physical therapy.

Petitioner attended physical therapy on ten occasions from September 25 through December 27, 2007, and continued working full duty. (PX7). At the time of a March 11, 2008 exam with Dr. Van, Petitioner complained of neck and bilateral shoulder pain as well as symptoms radiating to the right upper extremity. Petitioner testified he had not experienced such symptoms before the rear-end accident.

Because of the unremitting cervical and radiculating complaints, Petitioner underwent an EMG/NCV study with Dr. Bukowy on March 14, 2008 and a MRI of the cervical spine on March 16, 2008. Dr. Bukowy referred Petitioner to Dr. Brayton, a neurosurgeon. (PX8).

Dr. Brayton examined Petitioner on March 27, 2008 noting that he had neck pain immediately after the rear-end collision of December 5, 2006 and that there was no record of any pre-existing complaints. The MRI scan showed a large disc herniation at C4-5 and C5-6, causing very severe compression of the spinal cord. (PX9). Dr. Brayton performed surgery, a cervical decompression with an interbody fusion with hardware, at these levels, on April 1, 2008. (PX12). Petitioner discontinued working that day.

Postoperatively, Petitioner had difficulty swallowing, undergoing a video esophagram and speech therapy. He remained inpatient through April 7, 2008 and was fed mostly soft foods because of his swallowing difficulties. (PX12). Petitioner's condition improved postoperatively and he was released to modified duty on May 5, 2008 – no physical altercations – and told to attend physical therapy. He underwent x-rays of the cervical spine on May 20, 2008. The following day, he contacted Dr. Brayton's office, noted that he felt great with no pain or numbness, and asked to be return to work. Petitioner was released to return to work full duty effective May 22, 2008, though physical therapy was recommended to improve his mobility, endurance and strength. (RAX1).

Petitioner resumed working regular duty on May 22, 2008 and began physical therapy the following day. He performed all his assigned employment tasks, taking Advil, Tylenol and Flexeril as needed over the next 12 weeks. He did not lose any time from work because of his neck condition during this 12 week period. He attended eight physical therapy sessions at West Physical Therapy from May 23 through July 10, 2008. During a June 6, 2008 exam, Dr. Brayton recorded mild residual right-sided posterior neck stiffness and complete resolution of radiculating complaints. He did not schedule Petitioner for any additional exams. (RAX2).

While Petitioner was able to perform his employment tasks during this 12 week period, he noted that he did not have the same strength that he had had before the rear-end accident of December 5, 2006, particularly in his arms and shoulders. While performing daily activities during the months of May, June and July, 2008, he noticed neck stiffness. He had no complaints of pain or numbness in the left extremity and no complaints in the right upper extremity. He continued working full duty through August 23, 2008, the date of the second accident. Petitioner noted that while his symptoms had improved with surgery, he was not at 100%, and quantified his symptoms at 4 or maybe a 5 on a scale of 1 to 10 during this period.

On August 23, 2008 (10 WC 35376), Petitioner arrived at a forest preserve where he had to close the arms of a gate. He lifted one arm of the gate off its post and swung it shut. He estimated that the gate weighed over 100 pounds. He went to close the other gate and when he pulled it off the post, it dropped, struck his stomach, and swung him around onto the ground. Petitioner noted that following the incident he had neck, back and shoulder pain, and that he could not turn his head. He indicated that he called his partner who in turn transported him to the Delnor Community Hospital emergency room. Petitioner testified that he related his complaints to the doctor at that facility and x-rays were taken at that time.

Petitioner underwent a second MRI of the cervical spine on August 28, 2008. Dr. Brayton reviewed the MRI films and ordered physical therapy which Petitioner attended at West Physical Therapy on nine occasions from October 3 to November 6, 2008. Petitioner remained off of work during this period. (PX14).

Petitioner obtained a second opinion from Dr. Johnson, a neurosurgeon, on October 21, 2008. He was told to remain off work and continue with the prescribed conservative care. (PX10).

Dr. Brayton examined Petitioner on November 7, 2008 and found that he had recovered from the C4-5 and C5-C6 disc herniations incurred in the December 5, 2006 work injury, but had a new injury – namely, a large broad based disc herniation at 3-4 – which he felt was caused by the August 23, 2008 work accident. (PX9). Dr. Brayton recommended surgery to the C3-4 level and re-exploration of the previous fusion sites of C4-5 and C5-6. Dr. Brayton opined that the December 5, 2006 accident caused the C4-5 and C5-6 disc herniations requiring the April 1, 2008 surgery, and the second accident of August 23, 2008 caused the C3-4 disc herniation resulting in his recommendation of a second surgery. (PX9).

Dr. Lanoff conducted a §12 examination of Petitioner at Respondent's request on November 13, 2008. Dr. Lanoff diagnosed Petitioner with a cervical disc herniation at C3-4 related to the work accident of August 23, 2008, and possible right shoulder impingement and subacromial bursitis secondary to this work injury. (PX17). He noted Petitioner was fully functional until this August 23, 2008 injury. He recommended a subacromial injection to the right shoulder and physical therapy, and limited him to modified duty with no lifting more than 15 pounds, no overhead work, and no right-handed work.

Petitioner attended physical therapy on 11 occasions at Physiotherapy Associates from December 2, 2008 through January of 2009. On November 24, 2008, Respondent offered Petitioner modified duty within the parameters of Dr. Lanoff's return to work order. If he refused, then he would be considered "a voluntary quit." (PX11). Petitioner began working modified duty on December 1, 2008. Dr. Lanoff re-examined Petitioner on January 22, 2009 and suggested that he undergo injections or proceed with the surgery. Moreover, Dr. Lanoff noted that Petitioner was not at MMI. Petitioner continued to work modified duty and underwent a third cervical MRI on March 18, 2009. Dr. Brayton reviewed the MRI findings with Petitioner on March 30, 2009, and once again he found evidence of a large disc herniation at C3-4 and recommended surgery. (PX9).

In early April 2009, Petitioner had a conversation with his sergeant, Bill Glisson, who told him he was no longer a policeman. Petitioner testified that he thereupon walked out.

On April 9, 2009, Petitioner underwent surgery consisting of re-exploration and removal of plating from the C4-5 and C5-6 fusion site, a cervical discectomy and decompression and fusion with plating and screws at C3-4. (PX9). Following surgery, Petitioner could not swallow or eat. Consequently, a tube was inserted below his sternum that went into his stomach. Liquid was poured down the tube so he could be fed. Petitioner remained in-patient because of difficulty swallowing and eating and recommended speech therapy. He was discharged on April 18, 2009 with the feeding tube in place.

Petitioner continued with speech therapy and the liquid tube feeding with home visits from a health care nurse. (PX9). He attended physical therapy on seven occasions at West Physical Therapy from May 28 through July 9, 2009. (PX14). The feeding tube remained in place while he attended physical therapy. Moreover, Petitioner followed up with a speech therapist. (PX9). Speech therapy included video esophagrams. The feeding tube was removed on July 19, 2009 and Petitioner continued with physical therapy through September 4, 2009.

Dr. Brayton examined Petitioner on September 4, 2009 and recommended work conditioning four hours per day, three days a week, for six weeks. (PX9). Petitioner attended work conditioning at ATI First from September 25, 2009 through November 17, 2009. (PX15). Dr. Brayton discontinued the work conditioning because of complications involving the neck and left shoulder, and Petitioner's difficulty swallowing. (PX9). Later, because of Petitioner's continued complaints of difficulty swallowing and left paracervical muscle spasms, Dr. Brayton ordered a repeat cervical MRI and resumption of physical therapy.

Petitioner attended 16 physical therapy sessions at Delnor Community Hospital from January 22, 2010 through March 10, 2010. He underwent a third cervical MRI on March 29, 2010, and returned to Dr. Brayton on May 20, 2010 with complaints of pain and fatigue over the left paraspinous muscles. Dr. Brayton suspected Petitioner's symptoms were attributable to facet pain and recommended injections. (PX9).

Petitioner continued receiving treatment for difficulty swallowing and saw Dr. Lochmueller, an ENT, for these complaints beginning August 13, 2010. Also, because of ongoing left upper extremity complaints, Dr. Brayton referred Petitioner to Dr. Grosskopf, an orthopedic surgeon, who examined him and administered an injection on September 24, 2010. (PX16). Petitioner had little relief from the injection. On October 27, 2010, Dr. Grosskopf surmised that Petitioner's left upper extremity complaints were emanating from the cervical region.

Dr. Lochmueller examined Petitioner on November 5, 2010 at which time he noted 50% improvement in his difficulty swallowing and expected slow but gradual improvement. (PX9).

Dr. Brayton examined Petitioner on December 17, 2010 and recommended medical-based therapy including pool therapy and equipment. (PX9). Further, because of the restrictions in the cervical spine requiring the intermittent use of narcotic analgesics and muscle relaxants, and radicular symptoms in his dominant left arm, he did not believe it was reasonable for Petitioner to return to work in any capacity of law enforcement, even sedentary work that required the performance of paperwork. As a result, Dr. Brayton noted that Petitioner was permanently disabled from his occupation. Dr. Brayton also indicated that Mr. Harmon was at MMI and was to return on an as-needed-basis. (PX9).

Petitioner retained the services of vocational counselor Joseph Belmonte who conducted a vocational assessment on May 11, 2011. At that time Petitioner described his work history and educational background. Mr. Belmonte noted that Petitioner enlisted in the Marines at age 15 and was discharged because the minimum age was 17, that he worked 29 years for the City of Chicago as a police officer, returning in 1989, worked part time as a patrol officer for the Village of Elburn, had the ability to perform electrical, plumbing, heating and air conditioning, had a pilot's license, though had not undergone a mandatory annual physical since the early 1990s and earned a high school diploma at age 60. (PX25, pp.39-45). He also described dabbling in real estate. (PX25, p.43). Based on Dr. Brayton's December 17, 2010 work restrictions, Petitioner's educational and employment history and level of transferable skills, as well as his age (72 years old), Mr. Belmonte concluded that Petitioner did not have the ability to any perform a job identified in the labor market. (PX25, p.57). Mr. Belmonte also concluded that Petitioner was not a candidate for vocational rehabilitation as there was no accessible labor market. (PX25, pp.58,60). Further, he noted that given the restrictions imposed by Dr. Brayton, there was no basis to perform a labor market survey.

Following the vocational assessment with Mr. Belmonte, Petitioner continued to visit Dr. Brayton with complaints of persistent difficulties swallowing and choking, and progressively increasing neck pain, bilateral shoulder pain, worse on the left. On October 9, 2011, Petitioner underwent a fourth cervical MRI. In addition, he underwent a video esophagram on October 12, 2011. (PX9). Dr. Brayton reviewed the MRI results on November 4, 2011 and, because of changes at the C3-4 level and Petitioner's ongoing complaints, he

recommended a third surgery – specifically, cervical re-exploration from C3-C7 with plate removal and revision of the microforaminotomies. (PX9). Dr. Brayton related the need for surgery to the work injuries. (PX9).

Petitioner continued receiving benefits from Respondent throughout 2011. At the request of Respondent, Petitioner underwent a §12 examination with Dr. Zelby on March 12, 2012. At that time Dr. Zelby determined that Petitioner was at MMI and capable of working at the light to medium demand level, or 25 to 30 pounds occasionally and 15 to 20 pounds frequently. (RBX1). Petitioner's benefits were thereupon ceased on May 23, 2012.

Petitioner subsequently met with Ed Rascati of EJR Consulting for a vocational evaluation at Respondent's request on June 13, 2012. Mr. Rascati believed Petitioner was capable of security dispatch or customer service, but recommended a labor market survey. (RBX2). Respondent did not offer Petitioner vocational retraining or provide him with job placement assistance at that time.

On November 14, 2012, Dr. Brayton ordered an EMG/NCV study, flexion/extension x-rays of the cervical spine, and a fifth cervical MRI scan to address Petitioner's complaints of increasing neck pain and radicular symptoms. (PX9). Petitioner underwent the EMG/NCV study with Dr. Bukowy on November 20, 2012. On December 21, 2012, Petitioner reported worsening of his symptoms and was admitted to Delnor Community Hospital. Petitioner denied suffering any new injuries at that time. (PX23). He underwent x-rays and an MRI scan of the cervical spine on December 22, 2012. Petitioner was discharged December 25, 2012 with instructions to take Hydrocodone and follow up with Dr. Brayton. (PX23).

Petitioner acknowledged playing video chess on a laptop several times a month for several hours at a time. He denied any injury to his back as a result of said activity.

In the summer of 2013, Petitioner assisted his 95 year old mother who had suffered a light stroke, by performing some cooking tasks and light cleaning. Three or four service providers arrived daily to check his mother's vital signs, bathe her and attend to her needs. She eventually recovered from the effects of the stroke and Petitioner returned to his residence. Petitioner denied suffering an injury to his neck or left shoulder while assisting his mother that summer.

In the fall of 2013, Petitioner noted that his neck and left upper extremity pain persisted. As a result, he sought treatment at Delnor Community Hospital on September 4, 2013 complaining of left upper extremity pain progressively worsening in the days preceding the admission that had become uncontrollable. (PX20). Petitioner denied suffering any injury to cause these symptoms. He underwent a surgery, a C3 through C7 decompressive laminectomy with bilateral foraminotomies and facet fusion with bone graft by Dr. Brayton on September 10, 2013. (PX20). Petitioner was subsequently transferred to Marian Joy Rehabilitation Hospital for occupational and physical therapy on September 17, 2013. (PX21). Due to complaints of pain, Petitioner was thereupon transferred to Central DuPage Hospital on September 18, 2013. At that time he was diagnosed with intractable cervical neuropathic pain and transferred to Delnor Community Hospital. (PX20).

Petitioner remained at Delnor Community Hospital from September 18, 2013 through September 26, 2013. (PX20). During this period, a seroma, or a collection of blood, developed postoperatively and was drained. Petitioner was eventually discharged on September 26, 2013, although he remained under Dr. Brayton's care. Petitioner underwent a repeat vocational assessment with Mr. Belmonte on January 21, 2014. Mr. Belmonte's opinions as to Petitioner's employability and candidacy for vocational retraining, as well as job placement assistance, remained unchanged at that time. (PX26).

Petitioner attended physical therapy at DCH Health and Wellness from December 12, 2013 through February 17, 2014. (PX22, PX23). On that latter date, he was wearing a cervical collar and complained of left shoulder and arm pain. Therapy was put on hold because Petitioner had developed pneumonia. Dr. Brayton continued to keep Petitioner off work during this time.

During Petitioner's lengthy course of treatment, he intermittently visited Dr. Hamada, his PCP, for conditions unrelated to his cervical and upper extremity complaints. (PX19). In 2012, he noted that stress occasioned by the persistent pain in his neck and shoulder caused his spouse to move out of the house. Petitioner never had issues with stress before nor had his spouse left him in the past. As of September 24, 2014, Dr. Hamada found that Petitioner's musculoskeletal disorder precluded him from working as he could not sit for more than a half an hour, did not have use of the left hand, had no strength distally in his hand, exhibited tremors and weaknesses, and had chronic neck pain and tightness.

On October 13, 2014, Dr. Brayton examined Petitioner and concluded that it was unreasonable to consider Petitioner capable of gainful employment based on his severe spinal cord injury, persistent pain, reliance on daily narcotic analgesics, persistent myelopathy including orthostasis, as well as hypertonia and tremors. (PX9). In conjunction with this exam, Dr. Brayton completed an employability assessment dated November 10, 2014. He indicated that Petitioner could not engage in occasional carrying, could not engage in frequent lifting, could not engage in pushing or pulling, could stand and walk one hour per day or less, could not engage in climbing or balancing, was unable to perform reaching and handling, could handle communication capacities of three to five hours per day, could not stoop, crawl, kneel or crouch, could work inside 75% of the day and 25% outside, was unable to work in extreme cold, was unable to work in extreme heat, could not work in wetness or humidity, could not perform working involving jolting or jarring, vibration, could not work above six feet, around chemicals or with machines, and would need to alternate at will between sitting, standing, and walking. (PX9). Dr. Brayton noted that Petitioner could sit for up to 30 minutes before a positional change, stand for 15 minutes before a positional change, and would need to walk around. Further, his medications, in particular Norco, impacted his ability to work an eight-hour day. Moreover, there would be days he would be more limited because of dizziness and drowsiness. As a result, Dr. Brayton concluded that Petitioner was unable to work. (PX9).

Presently, Petitioner takes Norco, Lorazepam, Relafen and Flexeril daily that provides some relief. He continues to choke and cough from scar tissue in the cervical region. He cannot do any carpentry or electrical tasks, his neck gets stiff while driving causing him to stop and walk around. In addition to pain and stiffness in his left shoulder, he has numbness radiating down his left arm. He cuts his lawn with a riding mower, often stopping if his neck hurts. He has considerable atrophy in his arms and performs prescribed therapy exercises at home. He cannot stand or sit for an extended period of time; has difficulty sleeping because of his neck discomfort. Petitioner uses an electronic cervical collar and occasionally walks with a cane. He receives a police pension from his years of service with the Chicago Police Department, as well as Social Security benefits.

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

Dr. Brayton testified that the August 23, 2008 work injury caused a large disc herniation at C3-4 compromising the spinal cord and necessitating the surgery he performed on April 9, 2009. (PX26, p.39). He noted that Petitioner had a full recovery from the effects of the December 5, 2006 work injury that caused herniations at C4-5 and C5-6, had reached MMI and had returned to work without radicular deficits. (PX26. p.39). Dr. Brayton testified that the August 23, 2008 work accident caused a separate injury, new distribution of neck pain

and a return of symptoms that had previously resolved necessitating the resumption of care. (PX26, pp.41,42). As a consequence of the surgery, Petitioner developed complications post-operatively, including difficulty swallowing as well as left and upper extremity complaints, which have persisted through his course of care. (PX26, pp.44-47;83).

Dr. Brayton testified that the third surgery performed on September 10, 2013 was essentially the same surgery discussed with Petitioner as early as November 4, 2011 and again in December, 2012. (PX26, pp.66,72,76). He opined that the condition requiring this surgery was caused by the work injuries. (PX26, p.77). Dr. Brayton explained that the progressive hypertrophy and sclerosis of the articular facet at the operative levels caused posterior neuroforaminal stenosis and nerve root compression which were caused by or initiated by the December 5, 2006 accident. (PX26, p.77). He noted that initial x-rays showed minimal degenerative changes with a progressive multi-factorial posterior foraminal stenosis getting worse and worse as evident by later diagnostic studies, including six (6) MRI scans. Dr. Brayton testified that this injury to the neck caused the rapidly progressing facet disease that produced the severe nerve root compression. However, he stated that this surgery would have been less likely without the August 23, 2008 injury. (PX26, p.78).

Dr. Brayton explained that he had the luxury of imaging studies taken over the years that showed spondylotic changes, which at the onset were very minor given his age, and became dramatic after the injuries with a qualitative progression of spondylosis that began with the injury to the discs causing spinal cord nerve root compression. (PX26, pp.152,153). He noted that Petitioner recovered completely from the April 1, 2008 surgery, and was re-injured on August 23, 2008, after which there was a dramatic progression in the disc herniation with spinal cord compression at C3-4. He found the degeneration corrected during the September 10, 2013 surgery was traumatically induced, and by history, as well as review of the diagnostic studies, the acceleration of this traumatic inducement occurred after the August 23, 2008 work injury. (PX26, pp.152-156). Thus, Dr. Brayton was of the opinion that the work accident of August 23, 2008 was a causative factor of the condition of ill being necessitating the September 10, 2013 surgery. (PX26, p.158). Dr. Brayton did not believe playing online chess was an intervening accident. In regard to a discovery deposition given on April 16, 2009, relative to a civil action, Dr. Brayton testified that he rendered treatment for an additional four years, so that the opinions he expressed presently were accurate given the additional years of care. (PX26, p.159). Furthermore, Dr. Brayton testified that Petitioner was compliant with his treatment recommendations and was not capable of returning to gainful employment because of considerable weakness, chronic symptoms in the neck and left upper extremity, and need for pain management. Dr. Brayton characterized Petitioner as one of his most motivated patients to return to work. (PX26, pp.82,83).

At the request of Respondent, Petitioner visited Dr. Andrew Zelby on March 14, 2012 for purposes of a §12 examination relative to the August 23, 2008 accident. Dr. Zelby determined that Petitioner had reached MMI and was capable of functioning at a light to medium duty level. (RBX1, pp.9-10). Following his review of the medical records, Dr. Zelby concluded that the September 10, 2013 surgery was for degenerative changes and was not necessary or more likely due to the August 23, 2008 incident. (RBX1, p.18). Dr. Zelby noted that he had no knowledge or any history of a direct trauma to the neck occurring between Dr. Brayton's exam of November 4, 2011 and December 21, 2012. (RBX1, p.30). However, he agreed that Petitioner had had complaints since 2006 other than a period of relief following the April 1, 2008 surgery, and that records from December of 2012 and September, 2013 reference intractable or persistent neck pain. (RBX1,pp.50,51).

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's current condition of ill-being relative to his cervical spine is causally related to the undisputed accident on August 23, 3008. The record shows that following the August 23, 2008 incident Petitioner's cervical condition worsened requiring that he once again be taken off work and necessitating ongoing treatment for injuries, including surgeries to the

cervical region performed on April 9, 2009 and September 10, 2013. Prior to the accident in question, Dr. Brayton had found that Petitioner had reached maximum medical improvement and released him to return to full duty work, which he did on May 22, 2008. Following the accident on August 23, 2008, diagnostic studies revealed that he was suffering from a large broad-based disc herniation at a new level, C3-4, with a return of the cervical symptoms that had resolved with the April 1, 2008 surgery, as well as new symptoms in the left and right upper extremity, necessitating surgery at the C3-4 level with re-exploration of the earlier fusion site and a later multilevel surgery from C3-C7.

In further support of this finding, the Arbitrator relies on the opinion of Petitioner's treating surgeon, Dr. Brayton on the issue of causation, and finds Dr. Brayton's opinion along these lines to be more persuasive than those offered by Respondent's §12 examining physician, Dr. Zelby. More to the point, the Arbitrator finds that the August 23, 2008 incident aggravated Petitioner's underlying degenerative condition relative to his cervical spine, particularly in light of the fact, once again, that he had been released and was working at his old job at the time of the accident. In addition, while it is also true that Petitioner, as a man currently in his mid 70's, has suffered from multiple unrelated conditions throughout the pendency of these proceedings, and has received varying degrees of treatment for same, the evidence clearly shows that his cervical and lumbar spine conditions were, at the very least, a contributing factor in his ongoing disability. Likewise, while there were admittedly gaps in Petitioner's treatment during this time, there is no evidence to refute Mr. Harmon's claim that he has continued to experience cervical symptoms up through the date of arbitration or that he suffered some type of intervening accident that would have effectively broken the chain of causation. As a result, the Arbitrator finds that Petitioner's current condition of ill-being relative to his cervical spine is causally related to the accident on August 23, 2008.

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

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses incurred as a result of the August 23, 2008 in the amount of $40,707.36, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. These amounts can be broken down as follows:

1) Cadence Health (PX33) = $36,053.33
2) Marionjoy Rehab (PX32) = $2,902.96
3) CDH (PX31) = $208.25
4) Neurosurgery & Spine (PX26) = $1,542.82

Total = $40,707.36

The Arbitrator finds that Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.*, whether the claimant has reached maximum medical improvement.

Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 236 Ill.2d 132, 142, 337 Ill.Dec. 707, ___, 923 N.E.2d 266, 271 (2010). However, TTD benefits may be suspended or terminated before an employee reaches MMI if he: (1) refuses to submit to medical, surgical, or hospital treatment essential to his recovery; (2) refuses to cooperate in good faith with rehabilitation efforts; or (3) refuses work falling within the physical restrictions prescribed by his doctor. *Interstate Scaffolding, Inc.*, 236 Ill.2d at 146-47.

The fact that the employee is no longer receiving medical treatment or that he or she has the ability to do light work does not preclude a finding of temporary total disability. *Rambert*, 477 N.E.2d at 1370. On the other hand, it has also been held that the period of temporary total disability may terminate before the claimant has recovered to the full extent. *Lukasik v. Industrial Commission*, 124 Ill.App.3d 609, ___, 80 Ill.Dec. 416, 420, 465 N.E.2d 528, 532 (App.Crt. 1st Dist. 1984). Along these lines, the claimant must prove not only that he did not work, but that he was unable to work. *Gallentine v. Industrial Commission*, 201 Ill.App.3d 880, 559 N.E.2d 526 (1990).

In the recent case of *Sharwarko v. Illinois Workers' Compensation Commission*, 2015 IL App (1st) 131733WC, filed February 27, 2015, the Illinois Appellate Court held that the Commission's termination of TTD benefits based on the claimant's volitional act of removing himself from the work force was not against the manifest weight of the evidence. More to the point, the court held that "... when work for an injured employee falling within his medical restrictions is available, the employee's voluntary retirement is the equivalent to a refusal to work within those restrictions, authorizing the termination of TTD benefits before the employee has reached MMI." *Sharwarko*, 2015 IL App (1st) 131733WC, p.16; citing *City of Granite City v. Industrial Commission*, 279 Ill.App.3d 1087, 1090 (1996).

In the present case, Petitioner testified that he stopped working after the accident on August 23, 2008, and that he returned to modified duty with Respondent on November 25, 2008. He continued working modified duty thereafter up until the date of surgery on April 9, 2009. Petitioner testified that prior to that date he had a conversation with his supervisor, Bill Gleason, after which he "walked out" when he was told he "was no longer a policeman." Petitioner testified that he was taken off work following this surgery.

Petitioner noted that following surgery he experienced problems swallowing, and underwent therapy thereafter, including speech therapy and work conditioning.

In a report dated December 10, 2009, Dr. Brayton noted that Petitioner "... still requires Norco for pain on an intermittent basis..." and "... has met criteria for light duty release at work, but this cannot be allowed until he is independent of the Norco." (PX9). Petitioner testified that Respondent did not offer him a position within his restrictions at that time, and that he continued to receive TTD benefits thereafter.

Petitioner agreed that on March 11, 2010 Dr. Brayton released him to sedentary work with breaks every 30 minutes.

Dr. Brayton examined Petitioner on December 17, 2010 at which time he opined that Mr. Harmon had "... reached maximal medical improvement for purposes of Workers' Compensation", recommending that he continue with medical-based therapy and have access to a therapy pool. (PX9). In addition, Dr. Brayton noted that given that Petitioner is left hand dominant and has difficulty with paperwork due to radicular symptoms in his left arm, and in light of his restrictions with respect to the cervical spine and intermittent use of narcotic analgesics and muscle relaxants, "I do not feel that it is reasonable to expect him to return to work in any capacity of law enforcement, even sedentary work requiring performance of paperwork. Accordingly, I would

recommend that he be categorized as permanently disabled from his occupation." (PX9). Petitioner was released and instructed to return on an as-needed basis. (PX9).

Petitioner acknowledged that he has not looked for work since that time. He also agreed that he did not see Dr. Brayton again until September of 2013.

On March 14, 2012, Petitioner was examined by Dr. Zelby at the request of the Respondent. On that date Dr. Zelby opined that Petitioner had reached MMI and could return to work in a light to medium capacity with occasional lifting of 30-40 pounds and frequent lifting of 15-20 pounds. (RBX1).

Petitioner underwent another surgical procedure on his neck on September 10, 2013.

Petitioner testified that he last saw Dr. Brayton on October 13, 2014 at which time he was not released to return to work in any capacity. In his report on that date, portions of which were redacted by agreement of the parties, Dr. Brayton noted that while he felt Petitioner had "made a dramatic recovery from surgery, given the degree of his injury, spinal cord compression, and preoperative deficits, I still feel it is unreasonable to allow him to return to gainful employment... In summary, it is unreasonable to consider the patient for return to gainful employment [redacted portion omitted] based on his severe spinal cord injury, persistent pain and reliance on daily narcotic analgesics, persistent myelopathy including orthostasis, as well as his hypertonia and tremors." (PX9).

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner was temporarily totally disabled from August 24, 2008 through November 24, 2008, or the day before he returned to modified work, from April 9, 2009, the date of surgery, through December 10, 2009, when he was released to light duty work and absent evidence that he sought work within his restrictions, and from September 10, 2013, the date of surgery, through December 19, 2014, or the last date where Petitioner testified at arbitration, for a period of 115 weeks. The Arbitrator notes that in light of Petitioner's many non-work related conditions, and what the Arbitrator views as his effective retirement from Respondent in April of 2009 when he walked off the job, Petitioner simply failed to sustain his burden of proving by a preponderance of the credible evidence that the remaining time off work was related to the accident in question.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

In order to prove entitlement to permanent total disability benefits for life pursuant to §8(f) of the Act, a claimant must prove such a claim either (a) by a preponderance of the medical evidence, (b) by showing a diligent but unsuccessful job search, or (c) by demonstrating that because of his age, training, education, experience and condition no jobs are available to a person in like circumstances. See *ABB C-E Services v. Industrial Commission*, 250 Ill.Dec. 60, 737 N.E.2d 682, 316 Ill.App. 3d 745 (5th Dist. 2000).

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Industrial Commission*, 77 Ill.2d 482, 487 (1979). The employee, however, need not be reduced to total physical incapacity before a permanent total disability award may be granted. *Ceco Corp. v. Industrial Commission*, 95 Ill.2d 278, 286-87 (1983). Rather, the employee must show that he is unable to perform services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. *Alano v. Industrial Commission*, 282 Ill.App.3d 531, 534 (1996). If the employee's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, he may qualify for "odd

lot" status. *Valley Mould & Iron Co. v. Industrial Commission*, 84 Ill.2d 538,546-47 (1981). An odd-lot employee is one who, though not altogether incapacitated to work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market. *Valley Mould*, 84 Ill.2d at 547.

If employees fail to make out a prima facie case that they fall into the "odd lot" category, then it remains incumbent upon them to demonstrate that, given their present condition and in light of their age, training, experience, and education, they are permanently and totally disabled. *ABB C-E Services v. Industrial Commission*, 737 N.E.2d 682, 685, 316 Ill.App.3d 745, ___, 250 Ill.Dec. 60, ___ (Ill.App. 5 Dist. 2000); citing *Valley Mould*, 84 Ill.2d at 547. They may accomplish this by a showing of diligent but unsuccessful attempts to find work or by proof that because of the above mentioned qualities they are unfit to perform any but the most menial tasks for which no stable market exists. *ABB C-E Services*, 737 N.E.2d at 685. Thus, pursuant to the analytical framework set forth in *Valley Mould*, there are three ways by which employees can demonstrate that they are permanently and totally disabled: (1) by a preponderance of the medical evidence, (2) by showing a diligent but unsuccessful job search, or (3) by demonstrating that because of their age, training, education, experience, and condition, no jobs are available to a person in their circumstances. *Id.* at 686.

In the present case, treating surgeon Dr. Brayton clearly opined that Petitioner is unable to return to gainful employment as a result of his spinal injury. (PX9; RX26). Thus, it would appear that Petitioner would qualify as permanently and totally disabled based on the preponderance of the medical evidence.

In addition, it would appear that Petitioner would fall under an "odd lot" theory of PTD. Along these lines, Joseph Belmonte, a certified rehabilitation counselor, conducted a vocational assessment of Petitioner on May 11, 2011 and January 21, 2014. Later, he reviewed Dr. Brayton's October 13, 2014 progress report and six-page employability assessment of November 10, 2014. (PX35, p.7). Based on Petitioner's medical restrictions, his educational background, work history, and 72 years of age, he concluded that Mr. Harmon had lost access to all occupations he had performed throughout his work life, and even the ability to perform sedentary work. (PX25, pp.57,60-77,78). Mr. Belmonte could not identify any position for which a reasonably stable labor markets exists. Moreover, he noted that Petitioner was not a candidate for retraining. As a result, based on Petitioner's age, education, work history and physical capabilities of transferable skills, Mr. Belmonte felt that there was no viable stable market available to Mr. Harmon and that he did not have the potential to access any gainful employment through vocational rehabilitation or interventions. Based on the findings of Dr. Brayton of October 13, 2014, and his November 10, 2014 employability assessment, Mr. Belmonte concluded that Petitioner was not a candidate for any position in a reasonably stable labor market, nor was he a candidate for vocational retraining or job placement assistance. (PX35, pp.10-15). Furthermore, he believed that Petitioner's age and Dr. Brayton's employability assessment would not lead to the identification of any available jobs per the Dictionary of Occupational Titles. (PX35, pp.11-13).

Ed Rascati conducted a vocational assessment of Petitioner on June 13, 2012 at Respondent's request relative to the August 23, 2008 accident. Based on the employability assessment of Dr. Zelby, Mr. Rascati felt Petitioner was capable of security work, dispatch and customer service and possible retail. (RBX2, pp.10,33). However, Mr. Rascati did not conduct any vocational tests to assess Petitioner's language or math skills, nor did he identify any employer or specific positions available to Petitioner. (RBX2, pp.30,31). In September, 2014, he was directed to perform additional vocational services pending Dr. Brayton's updated employability assessment. Mr. Rascati agreed that Dr. Brayton's employability assessment on November 11, 2014 would render Petitioner unemployable. (RBX2, p.41).

Thus, Mr. Belmonte and Mr. Rascati would appear to agree that Dr. Brayton's employability assessment of November 10, 2014 renders Petitioner unable to perform any services for which a reasonably stable labor

market exists. Along these lines, the Arbitrator finds persuasive the employability assessments of Dr. Brayton, including that of November 10, 2014. Dr. Brayton found that Petitioner could not engage in any occasional carrying, frequent lifting, pushing or pulling, climbing or balancing, was unable to perform reaching and handling, and was limited to standing and walking of one hour per day or less. Moreover, he was unable to work in extreme cold, or heat, could not work in wetness or humidity, could not perform tasks that involved jilting, jarring or vibration, could not work at a height greater than six feet, or around chemicals or machines, would have to alternate between sitting and standing, the former after 30 minutes and the latter after 15 minutes. Likewise, his need for Norco impacted his ability to work eight hours a day. There was no credible evidence offered to rebut this employability assessment.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that he is permanently and totally disabled for life pursuant to §8(f) of the Act commencing December 20, 2014, or the day after he last testified at arbitration.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Respondent's conduct in the defense of this claim was neither unreasonable nor vexatious under the circumstances, given the multiple issues involved, including Petitioner's ongoing entitlement to TTD, and as such the imposition of penalties is not warranted. Therefore, Petitioner's claim for additional compensation pursuant to §19(k) and §19(l) and/or attorneys' fees pursuant to §16 of the Act is hereby denied.

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

Berwin Williams,

Petitioner,

vs. NO. 09WC 02332

State of Illinois Student Assistance Commission,

16IWCC0420

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator filed June 13, 2014 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: JUN 20 2016
SJM/sj
d-6/9/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed. Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

RECEIVED
DEC 2013
ILLINOIS WORKERS' COMPENSATION COMMISSION
PM 12:30

Employee/Petitioner Rerwin Williams

Case # 09 WC 02336

v.

Employer/Respondent State of ILLINOIS - Student Assistance Commission

TO: Asst Attorney General Gregg Gansman 100 W Randolph St Chicago, IL 60901

On FEB 4, 2014 at 9:00 AM, or as soon thereafter as possible, I shall appear before the Honorable O'MALLEY or any arbitrator or commissioner appearing in his or her place at New Lenox Illinois, and present the attached motion for:

- ☐ Change of venue (#3072)
- ☐ Consolidation of cases (#3071) (list case#)
- ☐ Dismissal of attorney (#3052)
- ☐ Dismissal of review (#3085)
- ☐ Fees under Section 16 (#1600)
- ☐ Fees under Section 16a (#1645)
- ☐ Hearing under Sect.19(b) (#1902)
- ☐ Penalties under Sect. 19(k) (#1911)
- ☐ Penalties under Sect. 19(l) (#1912)
- ☑ Reinstatement of case (#3074)
- ☐ Request for hearing (#R33)
- ☐ Withdrawal of attorney (#3073)
- ☐ Other (explain) ____

Signature Petitioner ☑ Respondent ☐

Attorney's name and IC code # (please print)

Name of law firm, if applicable

4813 J Mulberry
Street address

Pembroke Township, IL 60958
City, State, Zip code

815-933-4398
Telephone number

Sphanx66man@YAHOO
E-mail address

ORDER

The motion is set for hearing on 3/4/14 at 9:00 (Floor) (13)

Signature of arbitrator or commissioner

2-4-14
Date

ORDER

The motion is Denied

JUN 13 2014

- ☐ Granted
- ☑ Denied
- ☐ Withdrawn
- ☐ Dismissed
- ☐ Continued to ____
- ☐ Set for trial (date certain) on ____

Signature of arbitrator or commissioner

Date

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.

Serwid

Villa affirm that I delivered ☐ mailed with proper postage ☐ **16IWCC0420**

he city of Chicago copy of this form

11:50 AM on 12/6/13 to each party at the address(es) listed below.

Asst. Attorney General
Basman, Gregg
100 W Randolph St
Chicago, IL 60601

Signature of person completing *Proof of Service*

ned and sworn to before me on 6 Dec 2013

Theresa Montes
ary Public

"OFFICIAL SEAL"
THERESA MONTES
Notary Public, State of Illinois
My Commission Expires Nov. 27, 2016
Commission No. 777489

The Workers' Compensation Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.

ILLINOIS WORKERS' COMPENSATION COMMISSION
PETITION TO REINSTATE CASE

ATTENTION: This petition must be filed within 60 days of receipt of the dismissal order.

16IWCC0420

Berwin Williams
Employee/Petitioner

Case # 09 WC 02332

v.

State of ILLINOIS - Student Assistance Commission
Employer/Respondent

ILLINOIS WORKERS' COMPENSATION COMMISSION
2013 DEC -6 PM 12:30

On 4/4/13, this case was dismissed for want of prosecution. I received the dismissal order on _____. On _____, I will present this petition to reinstate the case before Arbitrator _____ for the following reason:

I was at the status call on last said Date. After all cases were heard I came to the Judge and informed him I was in the chamber. He informed me to go and have the case reinstated. I came down town twice the case was still in the system showing next call status for 7/11/13. I never received a dismissal notice.

Berwin Williams
Signature

Berwin Williams
Name (please print; attorneys, please include IC code #)

_____
Telephone number

12/6/13
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

MICHAEL DAMERY,

Petitioner,

vs.

NO: 15 WC 10247

MT. CALVARY LUTHERAN CHURCH,

16IWCC0421

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms the Arbitrator's award of forty percent loss of use of the left arm. The Commission, however, disagrees with the weight assigned to Damery's testimony regarding his desire to return to work as a pharmacist. Damery testified that he previously worked as a pharmacist and that he wanted to find employment as a part-time pharmacist. It was Damery's opinion that his injury would limit his ability to take items off of the pharmacy shelves and he would not be able to administer vaccinations. T.47-48. Damery testified, however, that he has not applied for any pharmaceutical jobs. T.61.

The Arbitrator found that Damery's inability to return to work as a pharmacist would have a negative effect on his future earning capacity. The Arbitrator assigned moderate weight to this factor despite there being no evidence as to how significant this negative factor might be.

16IWCC0421

The Commission finds Damery's testimony, in this regard, speculative as no evidence was offered that his work injury would preclude him from working as a pharmacist. Accordingly, the Commission assigns no weight to that factor. The Commission is otherwise in agreement with the Arbitrator's well-reasoned Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 17, 2015 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $73,100.00. 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: JUN 2 1 2016

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
D: 6-7-16
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DAMERY, MICHAEL
Employee/Petitioner

Case# **15WC010247**

MT CAVARY LUTHERAN CHURCH
Employer/Respondent

16IWCC0421

On 12/17/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.58% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2885 GONNERMAN REINERT LLC
MARK A GONNERMAN
222 S CENTRAL AVE SUITE 500
CLAYTON, MO 63105

2542 BRYCE DOWNEY & LENKOV LLC
JESSICA M RIMKUS
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

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
NATURE AND EXTENT ONLY

Michael Damery
Employee/Petitioner

v.

Mt. Calvary Lutheran Church
Employer/Respondent

Case # 15 WC 10247

Consolidated cases: n/a

16IWCC0421

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 William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on November 23, 2015. By stipulation, the parties agree:

On the date of accident, November 21, 2013, 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 $76,836.48; the average weekly wage was $1,477.62.

At the time of injury, Petitioner was 64 years of age, married, with 0 dependent child(ren).

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

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. At trial, the parties stipulated that Petitioner was paid his full salary in lieu of temporary total disability benefits.

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

ORDER

Respondent shall pay Petitioner the sum of $721.66 per week for 101.2 weeks because the injury sustained caused the 40% loss of use of the left arm as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

December 16, 2015
Date

DEC 17 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on November 21, 2013. According to the Application, Petitioner fell on a waxed floor and sustained an injury to his left arm/shoulder (Arbitrator's Exhibit 2). At trial, Petitioner and Respondent stipulated that Petitioner was paid his full salary in lieu of temporary total disability benefits and that all of the medical bills had been paid (Arbitrator's Exhibit 1). The only disputed issue was the nature and extent of disability.

Petitioner worked for Respondent as the Pastor of the church. Petitioner's job duties included providing spiritual guidance and counseling to members of the congregation, officiating at services, preparing sermons, etc. Petitioner also performed more physically demanding tasks which included moving chairs and tables when needed, changing the letters on the church sign which required the use of a ladder and placing/removing various items on overhead shelves. Further, Petitioner was required to drive approximately 400 miles per month to visit various members of his congregation.

On November 21, 2013, Petitioner was walking from the church sanctuary from a carpeted area onto a floor that had just recently been waxed. At that time, Petitioner's feet slipped out from under him and he fell landing on his left elbow. Petitioner testified that he did not have any prior left arm injuries, but, approximately one year prior he had sustained a right arm injury as a result of a motor vehicle accident.

Following the accident, Petitioner was seen in the ER of Decatur Memorial Hospital. X-rays were taken which revealed a comminuted fracture of the left humeral neck and proximal shaft extending toward the head (Petitioner's Exhibit 1; pp 58-60).

Petitioner was subsequently treated by Dr. Jeffrey Smith, an orthopedic surgeon. On November 22, 2013, Dr. Smith performed surgery which consisted of an open reduction and internal fixation of the left humerus fracture. The metal hardware consisted of a plate and several screws (Petitioner's Exhibit 1; pp 107-108).

Following surgery, Petitioner continued to be treated by Dr. Smith. When Dr. Smith saw Petitioner on December 5, 2013, Petitioner still had complaints of pain and the range of motion of the arm was limited. Dr. Smith recommended Petitioner perform therapeutic exercises at home (Petitioner's Exhibit 2; p 14).

Petitioner was again seen by Dr. Smith on January 2, 2014. At that time, Dr. Smith ordered physical therapy and directed Petitioner to continue with the exercises at home (Petitioner's Exhibit 2; p 15).

Petitioner received physical therapy from January 8, 2014, through April 24, 2014. When seen on April 24, 2014, the physical therapist noted that Petitioner had regained a normal passive range of motion but that Petitioner had difficulty regaining active abduction and flexion. The

physical therapist recommended that physical therapy be discontinued at that time (Petitioner's Exhibit 3; pp 2-3).

Petitioner was also seen by Dr. Smith on April 24, 2014, and he noted that the range of motion was improving. Dr. Smith saw Petitioner for the last time on July 8, 2014, and he noted that the range of motion had improved (Petitioner's Exhibit 3; pp 18-20).

At the direction of Respondent, Petitioner was examined by Dr. Mitchell Rotman, an orthopedic surgeon, on November 2, 2015. In connection with his examination of Petitioner, Dr. Rotman reviewed medical records provided to him by Respondent. On examination, Dr. Rotman noted some restriction of the range of motion of the left shoulder and that Petitioner complained of pain in the area of the metal plate. Dr. Rotman opined that Petitioner was not at MMI and he recommended Petitioner have the hardware removed because this could improve Petitioner's pain symptoms. Dr. Rotman opined that there was a five percent (5%) impairment rating of the left upper extremity based on the AMA guidelines (Respondent's Exhibit 1).

At trial, Petitioner testified that he still has pain in his left shoulder which he rates as 4/10. He also stated that the range of motion of his left shoulder is limited. Petitioner said that he now refrains from performing the physically demanding tasks such as changing the letters on the sign which required him to be on a ladder and use his arms in an overhead manner. He no longer helps in moving chairs and tables and he does not believe that it is safe for him to climb up/down ladders. Petitioner stated that his left arm is weaker than it was previously and he generally seeks assistance whenever he has to place or remove items from overhead shelves.

Petitioner also testified that his activities of daily living have also been affected by the injury. His ability to perform household tasks and play golf have been adversely affected. Petitioner continues to take pain medication on a daily basis.

Prior to becoming a Pastor, Petitioner was a pharmacist. He testified that, at one point in time, he was hopeful of returning to that job on a part-time basis. Because of the injury, Petitioner does not believe that he will be able to do so because of the various demands of stocking shelves, giving immunization injections, using both hands at eye level, etc., that are required of a pharmacist.

Conclusions of Law

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 40% loss of use of the left arm.

In support of this conclusion the Arbitrator notes the following:

Dr. Rotman opined that Petitioner had an AMA impairment rating of five percent (5%) of the left upper extremity. The Arbitrator gives this factor moderate weight.

Petitioner was a Pastor at the time of the accident. Many of Petitioner's job duties as a Pastor are not physically demanding; however, Petitioner also performed tasks that did require the active

use of his upper extremities including moving chairs/tables, changing the letters on the church sign which required climbing up/down a ladder, placing/removing items on overhead shelves, etc. The Arbitrator gives this factor moderate weight.

Petitioner was 64 years of age at the time of the accident. There was no evidence that Petitioner's age had any effect on the injury he sustained. The Arbitrator gives this factor no weight.

Petitioner worked as a pharmacist prior to becoming a Pastor and, because of this injury, Petitioner is no longer considering a return to that profession on a part-time basis. Petitioner's inability to return to work as a pharmacist will have a negative effect on his future earning capacity. However, there was no evidence submitted as to how significant this negative factor might be. Even so, the Arbitrator gives this factor moderate weight.

The treatment records clearly indicated that Petitioner sustained a significant fracture to the left humeral neck that required open reduction surgery with internal fixation with a metal plate and multiple screws. Petitioner's complaints and restrictions in regard to the use of his left upper extremity were consistent with the injury he sustained. The Arbitrator gives this factor significant weight.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Heather Watson,

Petitioner,

16IWCC0422

vs.

NO: 12 WC 21584

Silgan Containers,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 5, 2015, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,000.00. 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: JUN 2 2 2016
o6/8/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

16IWCC0422

WATSON, HEATHER
Employee/Petitioner

Case# **12WC021584**

SILGAN CONTAINERS
Employer/Respondent

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

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

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

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

0560 WIEDNER & McAULIFFE LTD
KHRIS DUNARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

16IWCC0422

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Heather Watson
Employee/Petitioner

v.

Silgan Containers
Employer/Respondent

Case # 12 WC 21584

Consolidated cases: n/a

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

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 (manifestation), April 19, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $41,600.00; the average weekly wage was $800.00.

On the date of accident, Petitioner was 34 years of age, single with 2 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $4,800.00 for other benefits, for a total credit of $4,800.00. At trial, the parties stipulated that TTD and maintenance benefits had been paid in full through February 15, 2015.

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

ORDER

Respondent shall pay reasonable and necessary medical services in the amount of $8,764.00 as identified in Petitioner's Exhibits 3, 4 and 8 for medical services provided to Petitioner as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner additional maintenance benefits of $533.33 per week for 28 1/7 weeks commencing February 16, 2015, through August 31, 2015, as provided in Section 8(a) of the Act.

Petitioner's Petition for penalties and attorneys' fees is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

October 28, 2015
Date

NOV 5 - 2015

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 April 19, 2012, and that Petitioner sustained an injury to the "Whole Body" as a result of "Repetitive bending, turning & twisting" (Arbitrator's Exhibit 6).

This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of maintenance benefits and medical bills. Petitioner also filed a Petition for Section 19(k) and 19(l) penalties as well as Section 16 Attorneys' Fees.

At trial, Petitioner claimed to be entitled to payment of temporary total disability benefits from March 22, 2013, through January 27, 2015 (96 4/7 weeks) and maintenance from January 28, 2015, through August 31, 2015 (30 6/7 weeks). Petitioner and Respondent stipulated that all temporary total disability and maintenance benefits had been paid through February 15, 2015, and that the disputed period of maintenance was from February 16, 2015, through August 31, 2015, a period of 28 1/7 weeks (Arbitrator's Exhibit 1).

In regard to medical bills, Petitioner tendered into evidence medical bills which totaled $8,764.00. Respondent did not dispute its liability for same and stipulated that the bills had either been paid or would be paid (Arbitrator's Exhibit 1).

This case was previously tried in a 19(b) proceeding on March 21, 2013, before Arbitrator Douglas McCarthy. Arbitrator McCarthy's Decision was filed with the Commission on April 12, 2013. Arbitrator McCarthy ruled in favor of the Petitioner and found that Petitioner sustained a compensable repetitive trauma injury to her low back and that her condition of ill-being was causally related to same. He awarded Petitioner temporary total disability benefits, medical bills and prospective medical treatment. The award for prospective medical treatment specifically ordered that Respondent approve and pay for an L5-S1 anterior lumbar interbody fusion with posterior instrumented fusion as recommended by Dr. Darvish and Dr. Rinella. Respondent filed a review of Arbitrator McCarthy's Decision with the Commission. With the singular exception of removing one sentence of Arbitrator McCarthy's Decision that did not alter his award, the Commission affirmed and adopted Arbitrator McCarthy's Decision in a Decision and Opinion on Review entered on April 22, 2014 (Petitioner's Exhibit 1). In spite of the preceding, Respondent disputed causal relationship when this 19(b) proceeding was tried (Arbitrator's Exhibit 1).

Dr. Anthony Rinella was Petitioner's primary treating physician and he performed back surgery on June 30, 2014. The surgical procedure consisted of a microdiscectomy at L5-S1 on the right side. Following surgery, Petitioner continued to be treated by Dr. Rinella who ordered physical therapy. When Dr. Rinella saw Petitioner on November 13, 2014, he ordered a functional capacity evaluation (FCE) of Petitioner (Petitioner's Exhibit 2; Deposition Exhibit 2).

The FCE was performed on January 20, 2015. According to the FCE report, Petitioner demonstrated "high levels of physical effort" during the testing. The physical therapist who performed the FCE noted that there was the presence of what he described as a "minor

inconsistency" in regard to the reliability and accuracy of Petitioner's complaints of pain and disability. However, he also noted that he was not implying intent on the part of Petitioner, but that Petitioner may have been able to do things, at times, beyond what she currently stated or believed (Petitioner's Exhibit 1; Deposition Exhibit 3).

The FCE examiner reviewed a statement of the physical demands of a Press Operator (the job Petitioner had at the time of manifestation) and concluded that Petitioner's physical abilities did not meet the job requirements. Specifically, the FCE examiner opined Petitioner could perform light to medium work with occasional lifting below waist height to 26 pounds; occasional sitting, bending, stooping, squatting, kneeling, carrying, stair climbing, ladder climbing and overhead reaching. The FCE examiner also opined that Petitioner was capable of walking on a constant basis (Petitioner's Exhibit 1; Deposition Exhibit 3).

Dr. Rinella subsequently saw Petitioner on January 28, 2015, and reviewed the report of the FCE. He opined that Petitioner was at MMI and imposed permanent work restrictions based on the FCE. Dr. Rinella opined that Petitioner was restricted from constant standing and walking (more than two-thirds of the day) and occasional sitting (up to one-third per day). He limited Petitioner's lifting to 20 pounds constantly and 50 pounds occasionally. He opined Petitioner could carry 20 pounds constantly and push/pull occasionally. In regards to Petitioner's agility, Dr. Rinella a restricted her from climbing ladders, as well as no repetitive stairs, crouching, crawling, twisting or bending (Petitioner's Exhibit 2; Deposition Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Donald deGrange, an orthopedic surgeon, on February 2, 2015. In connection with his examination of Petitioner, Dr. deGrange reviewed various diagnostic studies and medical reports including the report of the FCE. In regard to his examination of Petitioner, Dr. deGrange noted that it was a completely normal neurological examination. He opined that Petitioner was at MMI and could return to work without restrictions (Respondent's Exhibit 2).

Dr. deGrange was deposed on April 7, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. deGrange's testimony was consistent with his medical report and he reaffirmed his opinions that Petitioner was at MMI and could work without restrictions. In regard to the FCE, Dr. deGrange testified that he did not agree with its findings, primarily because of the subjective nature of the testing and the inconsistency noted by the examiner which Dr. deGrange described as "self-limiting behaviors." He opined that the examiner did not get a full and accurate view of Petitioner's physical capacities (Respondent's Exhibit 1; pp 18-20).

On cross-examination, Dr. deGrange stated that it would be "speculative" on his part to state that the FCE results were reliable. When questioned about whether he would rely on the FCE given Petitioner's minor inconsistency and her reliability regarding pain and disability, his response was "I do look at the report and I apportion an appropriate amount of weight to it. I wouldn't completely accept it or completely disregard it." Dr. deGrange then stated that the inconsistencies noted by the FCE examiner were not the reason for his opining that Petitioner could return to work without restrictions, but that it was the lack of objective findings on examination and his review of the diagnostic studies (Respondent's Exhibit 2; pp 26-28).

Dr. Rinella was deposed on August 19, 2015, and his deposition testimony was received into evidence at trial. In regard to the L5-S1 microdiscectomy surgery he performed on June 30, 2014, Dr. Rinella testified that he changed the surgical procedure from an interbody fusion to a microdiscectomy because he was not able to secure approval from the insurance carrier for performing the fusion surgery. Ultimately, Dr. Rinella performed the microdiscectomy and Petitioner made a good recovery subsequent to same (Petitioner's Exhibit 2; pp 13-16).

Dr. Rinella testified at length in regard to the FCE. He stated that if an FCE is well done (which it was in this case) then it is reliable in making a determination of work restrictions. He reaffirmed his opinion that Petitioner was at MMI and that the work restrictions he imposed were permanent. He specifically noted that Petitioner's physical effort findings were "reliable" (Petitioner's Exhibit 2; pp 17-21).

On cross-examination, Dr. Rinella was questioned about Petitioner's self-limiting behavior and he stated it was not present in this case. He was also interrogated about the minor inconsistency noted by the FCE examiner in regard to Petitioner's reliability and accuracy of her complaints of pain. Dr. Rinella responded that this did not cause him to have any level of concern. He also noted that the FCE was just one tool he used to determine what permanent restrictions were appropriate (Petitioner's Exhibit 2; pp 27-31).

At trial, Petitioner testified that she did a self-directed job search without the assistance of a vocational/employment expert. Petitioner stated that she did a significant amount of job searching online. Petitioner tendered into evidence a list of 13 jobs for which she submitted written applications between February 17, 2015, and August 20, 2015 (Petitioner's Exhibit 11).

Petitioner testified that she was hired by Teasdale Foods (the last employer on the list) and had just started working there on September 1, 2015. Petitioner works in inventory control and observes beans going by her on a conveyor belt and removing those that look bad. When she is working, Petitioner does have the option to sit or stand as needed. Petitioner stated that she still has some complaints of low back pain, especially with physical activity.

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 work-related repetitive trauma that manifested itself on April 19, 2012.

In support of this conclusion the Arbitrator notes the following:

In the prior 19(b) Decision, Arbitrator McCarthy found that there was a causal relationship between Petitioner's work activities and the condition of ill-being in her low back. This Decision was subsequently affirmed by the Commission.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services of $8,764.00 as identified in Petitioner's Exhibits 3, 4 and 8, 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:

In the prior 19(b) Decision, as affirmed by the Commission, Respondent was ordered to pay for prospective medical treatment. At trial, Respondent stipulated that these medical bills had either been paid or would be paid.

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

The Arbitrator concludes Petitioner is entitled to additional maintenance benefits of 28 1/7 weeks commencing February 16, 2015, through August 31, 2015.

In support of this conclusion the Arbitrator notes the following:

Both Petitioner's primary treating physician, Dr. Rinella, and Respondent's Section 12 examiner, Dr. deGrange, opined that Petitioner was at MMI on January 28, 2015, and February 2, 2015, respectively.

Respondent terminated Petitioner's maintenance benefits effective February 15, 2015, based upon Dr. deGrange's opinion that Petitioner could return to work without restrictions.

Dr. Rinella testified that the FCE was a reliable study and the fact that the FCE examiner noted what he characterized as a "minor inconsistency" did not cause him concern.

The FCE examiner specifically noted that the minor inconsistency of Petitioner's complaints of pain and disability was not indicative of any intent on her part nor did invalidate the study. The examiner specifically noted that Petitioner exhibited high levels of physical effort.

Dr. Rinella testified that Petitioner did not exhibit self-limiting behavior and that the FCE was one tool he used to determine appropriate work restrictions.

Dr. deGrange's testimony as to his opinion in regard to the FCE was unclear. He stated that he disagreed with it; however, he also said he would give it an appropriate amount of weight and would not completely accept or disregard it. The Arbitrator is unable to determine what weight, if any, Dr. deGrange gave the FCE; however, it appears as though he totally ignored the FCE because he opined that Petitioner could return to work without restrictions.

Based on the preceding, the Arbitrator finds the opinion of Dr. Rinella to be more persuasive and credible than that of Dr. deGrange.

While the evidence regarding Petitioner's job search is limited to her testimony regarding same and the list of jobs for which she made an application, the Arbitrator finds Petitioner's testimony to be credible. This was supported by the fact that Petitioner was successful in her efforts to secure employment.

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

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

In support of this conclusion the Arbitrator notes the following:

As stated herein, the Arbitrator found Petitioner's treating physician, Dr. Rinella, to be more persuasive and credible than Respondent's Section 12 examiner, Dr. deGrange, and has ordered Respondent to pay Petitioner maintenance benefits.

Dr. deGrange examined Petitioner and opined that she could return to work without restrictions. Respondent based its termination of maintenance benefits on Dr. deGrange's opinion and the Arbitrator finds that it was neither vexatious nor unreasonable.

In regard to the medical bills awarded herein, there was no evidence as to when the bills were tendered to Respondent or that Respondent has, in fact, refused to make payment of same.

William R. Gallagher, Arbitrator

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

Shane Mifflin,

Petitioner,

16IWCC0423

vs.

NO: 14 WC 38393

SOI Menard Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 23, 2015, is hereby affirmed and adopted.

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

16IWCC0423

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: JUN 2 2 2016
o6/8/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

16IWCC0423

MIFFLIN, SHANE
Employee/Petitioner

Case# **14WC038393**
15WC010882

SOI MENARD CORR CTR
Employer/Respondent

On 9/23/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% 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:

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

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

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

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

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

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

SEP 28 2015

DONALD A. HUBER, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0423

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Shane Mifflin
Employee/Petitioner

v.

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

Case # **14** WC **38393**

Consolidated cases: **15 WC 10882**

An *Application for Adjustment 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 **Collinsville**, on **July 30, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0423

FINDINGS

On the date(s) of accident, **September 29, 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 **$39,327.66**; the average weekly wage was **$756.30**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **1** dependent child.

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

Petitioner is entitled to temporary total disability benefits for the following periods: **10/31/14 – 2/23/15** and **2/26/15 – 7/30/15**, a period of 38 3/7 weeks.

Respondent shall be given a credit of **$13,234.71**for TTD, $- for TPD, $- for maintenance, $- for other benefits, and 5 service connected days.

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 of **$42,842.84**, subject to the Medical Fee Schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any medical bills previously paid.

Respondent shall pay Petitioner temporary total disability benefits of **$504.20/week** for a period of **38 3/7** weeks, commencing **October 31, 2014** through **February 23, 2015** and **February 26, 2015** through **July 30, 2015**, as provided in Section 8(b) of the Act. Respondent shall receive credit for TTD previously paid.

Petitioner's request for vocational rehabilitation and maintenance 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.

Nancy Lindsay
Signature of Arbitrator

September 19, 2015
Date

SEP 23 2015

Shane Mifflin v. State of Illinois Menard Correctional Center , 14 WC 38393 19(b)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This is one of two cases filed by Petitioner against Respondent. Case #14 WC 3839 alleges an accident date of September 29, 2014. (See AX 2). Case #15 WC 10882 alleges an accident date of February 25, 2015 (See AX 4). While consolidated for hearings, separate decisions are being issued.

The Arbitrator finds:

Petitioner had a work-related accident in September of 2008 when he helped a co-worker who was falling from a chair and twisted his neck and lower back. He began treating with Dr. Gornet and Dr. Adam Gibbs. During this time Petitioner underwent multiple MRIs of his cervical, thoracic, and lumbar spine as well as a cervical spine CT scan. Dr. Gibbs provided chiropractic care while Dr. Gornet prescribed physical therapy, lumbar epidural steroid injections, and limited Petitioner's work activities.

On February 24, 2009 Petitioner underwent a microdiscectomy at C6-7 with a disc replacement at C6-7. Low back surgery followed on July 7, 2009 (an anterior decompression at L4-5 and L5-S1, anterior lumbar fusion at L5-S1, and a disc replacement at L4-5). A follow-up CT scan of Petitioner's lumbar spine followed on October 12, 2009 and on February 8, 2010. As of February 8, 2010 Petitioner was continuing to improve with physical therapy and he was to return to work on March 16, 2010 after completing and finishing his home exercise program. He was to return in July for a repeat CT scan. On March 16, 2010 Petitioner was released to full duty work. (RX 12; RX 9)

On April 13, 2010 Petitioner settled his workers' compensation claim pertaining to the September 10, 2008 accident for 48% loss of use of a man as whole. (RX 13)

On October 26, 2014 Petitioner provided a hand-written accident statement to Respondent. In it he explained that he was closing the 20 tower hatch door (which weighed 30 -40 lbs.) on September 29, 2014 when he felt a sharp pain hit the middle of his shoulder blades. The handle of the door was made of rope and the handle slipped out of his hand. As he tried to catch it, he felt extreme pain run across his shoulders, up his neck, and down to the bottom of his spine. At around 5:10 p.m. he opened the hatch for another officer so Petitioner could leave on his lunch break and he felt worsening pain in the same areas of his body. When he returned and closed the hatch door the pain worsened. When he opened the hatch door to leave at the end of his shift, it again worsened. Petitioner worked again on September 30, 2014 and felt worsening pain each time he re-opened and closed the hatch door. (PX 10)

Petitioner signed his Application for Adjustment of Claim in case #14 WC 038393 on October 10, 2014 alleging back and neck injuries as a result of closing and opening a hatch door in the gun tower on September 29, 2014. (AX 2)

On October 31, 2014 Petitioner presented to Dr. Gornet indicating he had closed the tower hatch at work on September 29th and the rope slipped. While trying to catch it, he felt pain in the middle of his back and down to his tailbone and up to his neck/back of his head. Petitioner claimed disability as of October 4, 2014. Petitioner's main complaint was neck pain with headaches and pain between his

shoulder blades (esp. the right scapula and arm weakness). Petitioner's pain had progressively worsened since his accident. He thought it would go away and gradually improve and had been scheduled for a family leave of absence beginning on October 4, 2014. While off work, his pain progressively worsened and he reported the accident while off work. He denied any problems since his earlier treatment with the doctor. Petitioner also reported some low back pain to both sides but no significant leg pain. X-rays were taken showing no significant changes since the earlier surgeries. The doctor suspected some subtle foraminal stenosis at C7-T1 on the right side. They discussed the concept of structural problems in the spine and how they related to Petitioner's symptoms. The doctor felt Petitioner's symptoms were causally connected to the work accident. He recommended an "urgent MRI" of the cervical spine and physical therapy, heat, and oral steroids. In an Addendum, the doctor noted that the MRI showed a new annular tear with a central herniation slightly more to the right at C4-5 which the doctor felt correlated with Petitioner's symptoms in his right scapula and arm. Dr. Gornet took Petitioner off work. (RX 12)

Petitioner underwent a physical therapy evaluation on November 6, 2014. He gave a history of injuring his neck and back on September 29-30th while pulling on the tower hatch door in his tower and something "grabbed, caught, or popped" in his neck and back and he hurt all the way from his neck to his tailbone. Petitioner reported his symptoms worsened progressively and he went to Dr. Gornet who ordered a cervical MRI that showed a "torn disc." Therapy was begun. (RX 12)

Petitioner's lumbar spine MRI scheduled for December 18, 2014 was authorized by TriStar. (RX 12)

As of December 18, 2014 Petitioner was reporting ongoing scapular pain to Dr. Gornet, as well as low back pain. Dr. Gornet noted that Petitioner had a herniated disc at C4-5 which would account for his shoulder/shoulder blade pain. He further recommended an MRI and plain CT for Petitioner's lower back pain which he described as "significant." Petitioner underwent a lumbar spine MRI on December 18, 2014 that revealed: (1) artifact related to L4-5 intervertebral disc prosthesis and L5-S1 interbody devices which obscured evaluation at those levels; (2) moderate disc desiccation at L2-3 and a "likely" annular tear, a mild broad-based left paracentral disc protrusion, and mild left neural foraminal exit stenosis; and (3) moderate disc desiccation with diffuse annular disc bulge at L2-3 along with mild central anal stenosis and mild bilateral neural foraminal exit stenosis. (RX 12)

A CT of Petitioner's lumbar spine was performed that same day and revealed: (1) no significant change in the position of L4-5 disc prosthesis and two L5-S1 interbody devices with no evidence of hardware failure; (2) moderate disc desiccation with diffuse annular disc bulge and a mild broad based left paracentral disc protrusion and mild left neural foraminal exit stenosis; and (3) moderate disc desiccation with diffuse annular disc bulge at L2-3 with mild central canal stenosis and mild bilateral neural foraminal exit stenosis. (RX 12)

Dr. Gornet issued an Addendum after reviewing the foregoing films. Dr. Gornet noted new disc pathology at L2-3 and some facet changes at L4-5. Petitioner was advised his symptoms seemed consistent with facet irritation and he recommended anti-inflammatories and continued exercises.

Petitioner was advisef to remain off work and undergo a single epidural injection at L2-3 with facet blocks and rhizotomies at L4-5. (RX 12)

On January 7, 2015 Petitioner presented to Dr. Granberg regarding lumbar pain complaints. Petitioner had previously seen Dr. Granberg in 2009 when he underwent a series of lumbar (L5-S1) injections followed by an L5-S1 disc replacement and fusion procedure. Petitioner also had a history of a cervical artificial disc replacement and had been doing "relatively well" until September of 2014 when he bent over to pick up an object at work and experienced the recurrence of back pain which was not responding to conservative treatment measures. Petitioner was noted to have disc disease at L2-3 and L4-5 and was presenting for injections. Petitioner underwent such an injection at L2-3. (PX 6)

Petitioner returned to see Dr. Granberg on February 6, 2015 and underwent another injection only at L4-5. Petitioner reported 60% improvement from the first injection. (PX 6)

Respondent had Petitioner examined by Dr. Frank Petkovich on February 24, 2015. (RX5). Examination of the cervical spine showed decreased range of motion and some tenderness to palpation in the left and right paracervical areas. *Id.* Examination of Petitioner's lumbar spine demonstrated decreased range of motion and tenderness to palpation in the right and left paraspinous lumbar areas. *Id.* He stated, "The objective physical findings for [Petitioner] are consistent with his subjective complaints." *Id.* He cited the restrictions in range of motion and tenderness to palpation over the cervical and lumbar spine as evidence of same. *Id.* He did not believe that Petitioner had reached maximum medical improvement and could not state at the time when Petitioner would reach maximum medical improvement, "because this [would] depend on his response to any further evaluation and treatment." *Id.* He believed that Petitioner could work with restrictions of no lifting more than 5 pounds, and limited bending, stooping, kneeling, and squatting, and no inmate contact. *Id.* He believed that Petitioner should not perform the aforementioned activities no more than 4 times in one hour and that he should sit or stand every 15 minutes if necessary to alleviate discomfort. *Id.* He believed that Petitioner should eventually be able to return to his former job position without restrictions. *Id.*

On February 25, 2015 Petitioner completed an Incident Report regarding events of February 24, 2015. (PX 11) Petitioner wrote that he was advised to report to work on February 24, 2015 at 2:45 p.m. Petitioner did so and noticed his neck and back "greatly worsened" as the shift progressed. After completing the shift Petitioner left but he didn't get any sleep. Petitioner reported to work on the 25th and noticed he couldn't get comfortable in any of the chairs provided to him due to pressure on his low back and that the constant looking down and reading of mail caused neck and arm pain. Petitioner also reported having to engage in a lot of walking to get to the restroom. At approximately 7:15 p.m. his pain was so intolerable that he notified his shift commander and requested leave for immediate medical attention which was granted.

On February 25, 2015 Petitioner presented to the emergency room at Chester Memorial Hospital with the chief complaint of low back pain, described as chronic in nature but with an "acute injury" in September. Petitioner reported he had been called back to work the day before and made it through the day but with a lot of difficulty and was unable to complete his shift on the 25th. Petitioner

was noted to have tenderness, decreased range of motion, and muscle spasms on examination of his back. He reported taking up to 16 Ibuprofen per day. He was diagnosed with a back sprain and given two prescriptions and advised to follow up with his primary care physician. He was also encouraged to call his neurosurgeon for further care and follow up. He was given an off work slip for five days. (PX 7)

On March 3, 2015 Dr. Anthony Keele completed a CMS Physician's Statement indicating Petitioner was unable to work until March 17, 2015 due to a Class 5 physical impairment. (RX 7)

By letter dated March 9, 2015 Michelle McAffee, a TriStar Claims Examiner, notified Petitioner that his September 29, 2014 accident was not compensable as "[it] does not appear to have arisen out of and in the course of [Petitioner's] employment...." (RX 14)

On March 12, 2015, Petitioner received another letter from Tristar dated March 9, 2015 pertaining to his September 29, 2014 injury. The claims examiner, Linda Saunders, advised Petitioner that it was her understanding that Petitioner had returned to work on February 24, 2015 in light of the IME report of February 16, 2015. She further acknowledged a note from February 25, 2015 indicating Petitioner was unable to return to work; however, she had not received a medical note explaining the change in his medical condition and, therefore, Tristar was suspending Petitioner's indemnity benefits until such time as the medical note was received and his "change of condition" "clarified." (PX 10)

On March 13, 2015 Petitioner acknowledged receiving his "worker's [sic] compensation information packet." He also signed an authorization to release medical information and he completed a Notice of Information for Tristar. In it he described an injury date of February 25, 2015 and noted that he had been ordered to return to work on February 24 and had complied with the order. He wrote:

The pain in [my] neck and back greatly worsened as the shift went on. [I] managed to finish the entire shift on February 24th. [My] pain was so great that I didn't get any sleep at all after working on the 24th of February. [I] reported for work again on the 25th of February at approximately 2:40 p.m. [I] could not get comfortable in any of the chairs provided at all, put lots of pressure on low back. All of the constant looking down reading of mail caused more pain in neck and arms. There wasn't any running water, no use of bathroom, no sink to wash hands, causing [me] to walk back and forth to institution. At approximately 7:15 p.m. on February 25th [my] pain in neck back [were] excruciating and intolerable. [I] notified shift commander, Major Paige, and requested to leave for immediate medical attention. Major Paige granted request. [I] went to Chester Memorial Hospital Emergency Room. [I] was seen by Dr. Scott Hinze. [I] was given (2) two prescriptions and an unable to work slip for (5) five days. Dr. Hinze also advised [me] to make an appointment with spine surgeon as soon as possible. (PX 10)

Petitioner presented to Dr. Granberg on March 13, 2015 and underwent another injection at L2-3. (PX 6)

On March 26, 2015 Petitioner was advised, in writing, that his claim regarding an accident on February 25, 2015 was being denied, "...since there is no actual injury." The claims examiner added, "There is no denial an incident occurred, only that an injury was not sustained at this point as a result of the incident." (RX 14)

On March 30, 2015 Petitioner signed his Application for Adjustment of Claim in Case # 15 WC 010882 alleging back and neck injuries as a result of an "aggravation" on February 25, 2015. (AX 4)

On April 3, 2015 Dr. Granberg gave Petitioner another injection at L4-5. (PX 6)

On April 23, 2015 Dr. Gornet again met with Petitioner. A lot of his office note has to do with commentary directed at Dr. Petkovich's IME. Dr. Gornet stressed that he felt it was the combination of his accident in conjunction with Petitioner's pre-existing problems which had caused Petitioner's current level of symptoms, discomfort, and need for treatment. He noted Dr. Petkovich felt Petitioner could work light duty alternating between sitting and standing every 15" and avoiding inmate activity. Dr. Gornet added, "Unfortunately, Mr. Mifflin went to the mailroom and [couldn't] tolerate this activity." Dr. Gornet did not believe Petitioner was permanently, totally disabled; rather, he felt he was, at a minimum, capable of light duty work. He believed Petitioner's continued symptoms and pain. Dr. Gornet recommended a CT discogram at L3-4 andL2-3. Petitioner remained off work. (PX 3)

Petitioner underwent a discogram with Dr. Gornet on May 27, 2015, which revealed a non-provocative disc at L3-4 and a provocative disc at L2-3. (PX 8)

On June 6, 2015 Petitioner was examined by Dr. Anthony J. Keele at Cape Family Practice for anxiety, low energy and fatigue. Petitioner received LipoB and testosterone injections. (RX 10)

On June 8, 2015 Petitioner again saw Dr. Gornet. Dr. Gornet noted Petitioner's work-related injury on September 29, 2014 with ongoing significant low back pain and neck pain into the shoulders. Since surgery at L2-3 would be extremely difficult, he recommended an FCE. Petitioner was to remain off work. (PX 3)

Dr. Gornet's deposition was taken on June 11, 2015. (PX 12) Dr. Gornet is a board certified orthopedic surgeon. He testified that he had treated Petitioner before September 29, 2014 but had last seen him on February 8, 2010 at which time Petitioner was working full duty with no restrictions and doing well. During that earlier treatment Petitioner underwent surgery at L4-5 and L5-S1 (disc replacement and fusion) and a disc replacement at C6-7. (PX 12, pp. 7, 9) He then saw Petitioner on October 31, 2014 and he gave a history of an accident at work on September 29, 2014. (PX 12, p. 7) At that time Dr. Gornet felt Petitioner might have some structural issues going on with his neck and lumbar spine but it was difficult to fully evaluate him given the artifact in his spine. Therefore, he recommended conservative treatment, including injections and physical therapy. (PX 12, p. 9)

Dr. Gornet re-examined Petitioner on December 18, 2014 at which time Petitioner was reporting significant problems and an MRI and CT were preformed which showed an annual tear at L2-3 and mild facet changes at L4-5. Dr. Gornet believed Petitioner's symptoms were more consistent with irritation of his facet joints at L4-5 and he recommended off work status, exercise, anti-inflammatories, and a steroid injection at L2-3. (PX 12, pp. 9-10) Dr. Gornet testified that Petitioner has a disc herniation at C4-5, an annular tear at L2-3, and irritation of his facet joints at L4-5 all of which were caused by his work activity that he described occurring on September 24, 2015. (PX 12, p. 10)

Dr. Gornet testified that Petitioner's neck seems to be slowly improving while his low back remained an ongoing problem. He did feel the steroid injection at L2-3 was of some benefit. Dr. Gornet has also recommended facet rhizotomies at L4-5 and a second injection at L2-3. (PX 12, p. 11) Petitioner remained off work while undergoing those procedures. (PX 12, p. 12)

Dr. Gornet testified that when he re-examined Petitioner on March 9, 2015, Petitioner reported having seen Dr. Petkovich and being returned to full duty which Petitioner couldn't handle due to too much bending.

Dr. Gornet testified that he received a copy of Dr. Petkovich's report and while the doctor recommended a CT myelogram, Dr. Gornet believed a CT discogram would be more appropriate as it would allow him to determine if the annular tear was symptomatic. (PX 12, p. 13) Therefore, Dr. Gornet proceeded with the discogram which showed a painful disc at L2-3 and a normal disc at L3-4. (PX 12, p. 13)

Dr. Gornet further testified that he has no plans to perform surgery on Petitioner as he believed it would be difficult to perform a disc replacement at L2-3 and a fusion at that level would not be good as it would leave Petitioner sandwiched between two other fusions which isn't good on a long-term basis. He felt Petitioner's best option would be a functional capacity evaluation with permanent restrictions. (PX 12, p. 14) As of the date of his deposition Petitioner remained off work. When he receives the FCE, Dr. Gornet's plan is to place permanent restrictions on Petitioner and find him to be at maximum medical improvement. (PX 12, p. 14)

On cross-examination Dr. Gornet testified that he saw Petitioner on June 8, 2015 at which time they went over the discogram and the doctor explained that surgery wasn't a viable option. He went on to testify that Petitioner's low back is "overwhelming" to Petitioner and while his neck complaints/pain is still present, the low back takes precedence. Dr. Gornet felt that if he couldn't solve Petitioner's low back there was no reason to move forward on his neck because it's the lesser of the two problems. (PX 12, pp. 16-17) Dr. Gornet agreed that Petitioner has no significant radicular symptoms or substantial nerve irritation at this point in time. Initially, he had some upper extremity changes but those had resolved by the time of the doctor's deposition. (PX 12, pp. 17, 18)

Dr. Gornet testified that Petitioner has an annular tear at L2-3 and a herniated disc at C4-5. Both are structural problems/musculoskeletal issues and not necessarily amenable to surgery to get him back to a high level of functioning. Degenerative disc disease is not a structural problem presumably because it is not accompanied by disabling neck or low back pain. (PX 12, pp. 20-21) It is, however, a structural change of the spine. (PX 12, p. 21) According to Dr. Gornet, the difference between a change and a problem is that the latter produces symptoms. (PX 12, p 21)

Dr. Gornet acknowledged that Petitioner is a "big guy." They did not discuss his recreational activities or whether he worked out or lifted weights. (PX 12, pp. 23-24) He agreed that Petitioner had some degenerative disc disease in his neck and low back before his accident. His causation opinion is based upon Petitioner's history to him. (PX 12, p,. 25) To date, Dr. Gornet did not believe Petitioner had ever misrepresented anything. He also didn't believe Petitioner was taking any significant narcotics when first seen. (PX 12, p. 28) He didn't recall if Petitioner was a smoker. (PX 12, p. 29) He thought he took Petitioner off work as of Octob er 31, 2014. (PX 12, p. 29) He remained off work as of December 18, 2014 as the doctor recalled Dr. Petkovich sending Petitioner back to work and he only lasted one day in the mail room. He didn't think Petitioner could tolerate work. At that time he recommended Petitioner continue with exercises and anti-inflammatories. (PX 12, pp. 31-32) Dr. Gornet explained that physical

therapy and injections provided no lasting benefit or improvement. He doesn't feel work hardening is appropriate; rather, Petitioner should undergo a functional capacity evaluation followed by permanent restrictions. Dr. Gornet does not believe Petitioner is permanently and totally disabled but he does feel that with appropriate restrictions and training Petitioner should be able to find a job. (PX 12, pp. 33-34)

Dr. Gornet further testified that as of their February 23, 2015 visit Petitioner remained off work. He then re-examined Petitioner on March 9, 2015 which was right after Dr. Petkovich had released himi to return to work with no restrictions. Dr. Gornet felt he should remain off work. He then re-examined him on April 23, 2015 at which time he had a copy of Dr. Petkovich's IME report. In Dr. Gornet's opinion Dr. Petkovich is trying to say that Petitioner's problem is degenerative and that the accident did not cause any acceleration or problem. However, according to Dr. Gornet, Petitioner's problem is not related to disc degeneration and Dr. Petkovich did not address or explain his opinion or why Petitioner didn't have any problems before the accident. Dr. Gornet agreed with Dr. Petkovich that Petitioner had pre-existing disc degeneration and that the accident didn't accelerate that; however, he believed the accident caused an annular tear at L2-3. (PX 12, p. 37)

Dr. Gornet acknowledged that individuals with degenerative disc disease can have waxing and waning symptoms. (PX 12, p. 37) He further testified that Dr. Petkovich felt Petitioner's accident caused his current symptoms but the diagnosis was a cervical, thoracic, and lumbar strain. In sum, he felt both doctors agreed that the accident caused Petitioner's symptoms but they disagree as to the diagnosis caused by the accident. (PX 12, p. 38)

Dr. Gornet went on to testify regarding a note in his April 23, 2015 office record in which he stated he felt Petitioner would be capable of light duty and that he was not permanently, totally disabled. Dr. Gornet explained that what he meant to make clear was that Petitioner was not heading for disability but he may require some permanent restrictions. He felt Petitioner was better off remaining off work while the doctor was trying to fix the problem and so he remained off work. (PX 12, pp. 38-39) Dr. Gornet reiterated that Petitioner felt he could not perform light duty. (PX 12, p. 40)

Dr. Gornet testified that he will not release Petitioner to light duty or with permanent restrictions until he receives the FCE. There might be a possibility Petitioner could work with a 5 lb. restriction as of June 8, 2015. It would need to be something very sedentary. The doctor explained, "That would be reasonable at this point because now we known that he will probably require permanent restrictions, and since those are the lowest level of restrictions, I would agree with you that that would be within his realm, and then I will set permanent restrictions later on. (PX 12, pp. 41-42) He would have no problem with Dr. Petkovich's restrictions of February 2015 at this point in time. (PX 12, p. 42-43)

Dr. Gornet was unaware of any reports from Petitioner that he was having difficulty walking due to his back injury. He did note that Petitioner reports his pain affected all aspects of his life. He had not detected any radiating pain down Petitioner's legs recently. If Petitioner complained of radiating leg pain after the discogram that could be possible as it easily occurs. It would not be an unusual complaint given Petitioner's structural problem at L2-3. (PX 12, p. 44) He did not complain of any on March 9, 2015. (PX 12, p. 46)

Dr. Gornet testified that the imaging studies he ordered in October of 2014 were warranted based upon a new onset of symptoms attributable to a mechanical type of injury that could easily produce a disc injury that the doctor felt was a dramatic change in Petitioner's condition. (PX 12, p. 50) He then explained that as of March 2015 he had Petitioner temporarily totally disabled but Respondent

had returned Petitioner to work in the mail room which aggravated his condition and there was no reason to document a lot of new findings or do new tests because they were dealing with a manifestation of an aggravation of a condition the doctor believed Petitioner already had. (PX 12, p. 51) Dr. Gornet acknowledged that his office note for the March visit indicated Petitioner had no new neurological complaints and that pain radiating down both of one's legs could be such a complaint he would have noted if he felt it was clinically warranted. (PX 12, p. 52)

Dr. Gornet agreed that Petitioner' main complaints as of October 31, 2014 was neck pain radiating into his shoulder. He also noted low back pain to both sides but no significant leg pain. (PX 12, pp. 52-53) The doctor did not know Petitioner's work status as of October 31. Petitioner did advise Dr. Gornet that he was off work on a pre-planned leave due to a family matter but his pain was progressively becoming worse while he was off work. (PX 12, p. 56) Dr. Gornet further acknowledged that weight lifting could cause problems with discs if the mechanical load was fairly large. He did not know if Petitioner was on testosterone. (PX 12, p. 56)

Petitioner underwent a functional capacity evaluation (FCE) on June 29, 2015 at ApexNetwork Physical Therapy. (PX 9) Petitioner gave a history of closing a solid steel door (weighing up to 100 lbs.) when the strap slipped and he grabbed for the door, immediately getting pain in his low back and neck. This occurred on September 29, 2014. Petitioner explained that the pain worsened and he eventually went to Dr. Gornet who had previously performed surgery on him. Testing was done and therapy was of no benefit. Injections did not help either. Dr. Gornet had recommended the FCE. Petitioner reported pain in his legs bilaterally with a constant needle-like sensation to his toes. All tasks aggravated him although walking was not too bad. Bending, squatting, and sleeping were difficult. He could not cut grass or lift due to pain. Petitioner reported job tolerances in the heavy/very heavy work demand level as he would need to be able to lift over 100 lbs. The evaluator noted the Dictionary of Occupational Titles for Correctional Officers described the work demand level as "medium." Petitioner's effort was described as "good." Petitioner's subjective complaints of pain during testing were described as "high", starting at "6/10" and increasing up to "7/10." Increases in heart rate reflected good effort. Petitioner's pain questionnaire reflected Petitioner's own perception of his condition as "severe/crippled." The evaluator also felt Petitioner was guarding somewhat most likely due to pain. (PX 9)

On June 29, 2015 Petitioner underwent the FCE. Petitioner described his job duties as being in the "heavy/very heavy" work demand level. The Dictionary of Occupational Titles described correctional officers' duties as "medium" level work. The evaluator concluded that Petitioner "displayed function in the 'light' physical demand level" and his performance was consistent with good effort. Petitioner was noted to have high subjective pain complaints and pain levels appeared to play a role in his performance and limited lifting ability. In his Perceived Disability Questionnaire, Petitioner did perceive himself as severely disabled/crippled. (PX 9)

Petitioner's cases proceeded to arbitration on July 30, 2015. At the time of arbitration, the issues were the same for both cases: accident; causal connection; medical bills; temporary total disability benefits; vocational rehabilitation; and maintenance benefits. Two witnesses testified at the hearing: Petitioner and Respondent's representative, Cindy Cowell.

Petitioner testified that he has been a Correctional Officer for Respondent for 18 years. On September 29, 2014, he was injured when he was closing a hatch door in a tower. The door, depicted in Respondent's Exhibit 7, is a large, full-size rectangular door in the floor with a heavy appearance. (RX 7) Petitioner testified that a leather strap was affixed to the hatch because there was no handle. Petitioner

testified that on the aforementioned date the door slipped out of his hand, and when he lunged and caught the door, something weird popped/pulled in his lower back. When questioned as to why he did not immediately report his injury, he replied that he didn't think it was a major issue at first but the pain kept getting worse and worse and worse as time went on. Petitioner finally reported his injury on October 26, 2014 because he couldn't stand the pain anymore and had to have it looked at. He explained that he thought it was a minor issue but he was wrong and it kept getting worse.

Petitioner's incident report, completed by Samantha Carmona, recorded the history of injury as, "EE stated the door slipped out of his hand and he tried to catch it, EE caught it and injured neck, middle back, lower back." (RX1).

Petitioner testified that he sustained no other injuries to his low back, did not require any low back treatment, and did not take any narcotic medication for his low back between the time he settled his prior back injury in 2010 and he had his accident in September of 2014. Petitioner also denied missing any time from work between 2010 and 2014 on account of his low back.

Petitioner testified that he was moved from the tower after the accident but he didn't recall when and he testified to problems with the new job. Petitioner's leave of absence began on October 7, 2014.

Petitioner testified that he saw Dr. Petkovich on February 16, 2015 and went back to work on Monday, February 24, 2015. Petitioner testified that Dr. Petkovich indicated to him that he wasn't at maximum medical improvement and that he needed additional testing.

Petitioner testified to giving a good faith effort at his return to work in the mailroom. The job he was given required lots of bending, stooping to pick up mail, movement of mail, reading, and sitting in chairs like the ones in the hearing room (hard plastic, with no cushion). Petitioner testified that these activities caused his pain to increase greatly. As a result he completed an incident report on February 25, 2015 describing what had happened and he returned to see Dr. Gornet.

Petitioner testified that he cooperated with the functional capacity evaluation.

Petitioner testified that the injections ordered by Dr. Gornet improved his condition very little.

Petitioner testified that he is ready and willing to perform light work and/or comply with vocational efforts made on his behalf. Petitioner testified that he has not been back to see Dr. Gornet since he underwent the FCE. He is scheduled to see him on August 24, 2015.

On cross-examination Petitioner testified that he was working the 3:00 to 11:00 shift on September 29, 2014. He was assigned to the medium security unit that day and had only been there four or five months. Prior to that Petitioner had been assigned to Menard General Division Correctional Center. Petitioner testified that he was assigned to 20 tower on the 29th and had been in the tower prior to that time approximately two weeks. Petitioner explained that he is required to report to duty at 2:45 for roll call and he is then to report to the tower at 3:00 to relieve the previous officer. Petitioner explained that the officer he is relieving opens the hatch to let him into the tower, then leaves, and

Petitioner would be responsible for closing the hatch door. Petitioner explained that the hatch door can only be opened from inside the tower by manually lifting it and if the door had fallen without being caught by him it would have made a very loud bang. Petitioner acknowledged that he did not tell anyone about the incident when it occurred.

Petitioner further testified that at 5:10 he went on his lunch break and had to open the hatch door to allow the relief officer in. Petitioner testified that he noticed pain at that time but, again, said nothing about it. After his lunch break Petitioner again returned to the tower, was let in by the relief officer, and then had to close the hatch door himself. He noticed extreme pain when doing so but did not tell anyone about it. Petitioner acknowledged that at the end of his shift he didn't tell anyone about his pain. He also worked the next day and in the same tower and had to close/open the hatch and, again, said nothing about it adding that he didn't think it was a major issue at first but then the pain kept getting worse as time went on.

Petitioner acknowledged that he reported his accident on October 26, 2014. Petitioner was asked if he was assigned to work in the tower between October 1st and October 26th and he replied that he was moved but unable to recall the exact date. When asked if he had any problems with his back during that time period at his new job, Petitioner replied "very much so" but he acknowledged not making out any further incident reports.

Petitioner acknowledged beginning a leave of absence on October 7, 2014 to care for his girlfriend who had been diagnosed with cancer and needed assistance and support while undergoing treatment. Petitioner explained that he finally reported the accident in late October because he could no longer stand the pain and needed to have it looked at.

Petitioner was asked about a leave of absence he took while working at Menard in 2013 and explained that that absence was connected to a divorce. He also had a close family relative die and took time off between March of 2013 and March of 2014.

Petitioner testified that he had no problem with being moved to tower 20. He denied any incidents involving his back between October 7 and October 26, 2014.

Petitioner acknowledged that he contacted his attorney before he contacted any doctor. He then went and saw Dr. Gornet on October 31, 2014. He filled out the Incident Report before he saw his attorney.

Petitioner denied that he is a weight lifter.

Regarding his light duty assignment in the mail room, Petitioner testified that he was given instructions regarding what to do by other officers. He worked there one full shift and a little under a half a shift the next day (February 24 and 25th) He then went to Chester Memorial Hospital ER and, later, Dr. Gornet.

Petitioner was asked if he told Dr. Gornet that Dr. Petkovich had released him to full duty work as that is what the doctor's notes state. Petitioner acknowledged same. Petitioner further acknowledged

that he told the FCE evaluator that his job required him to lift 100 to 200 pound property boxes from floor to waist and that it can be in the "heavy/very heavy" work demand level. He did not recall being told by anyone that his job was at a "medium" work level.

On redirect examination Petitioner explained that he didn't say anything to his co-workers or complain because he isn't that kind of person and thought he could fight through it. Petitioner also acknowledged undergoing previous back surgery and testified that he really doesn't want to go through it again. He also acknowledged that he simply misspoke when he told Dr. Gornet he had been released to full duty by Dr. Petkovich.

On further cross examination he denied that he misspoke when he described his job as "heavy/very heavy."

Cindy Cowell testified on behalf of Respondent. Ms. Cowell is the office coordinator/work comp coordinator for Respondent. She acknowledged that at some point she received paperwork indicating Petitioner could return to work with some restrictions and his could be accommodated. Ms. Cowell testified that Petitioner was assigned to the mailroom; however, she had no knowledge regarding his job duties there. She did not know how he did in the mailroom and she did receive an incident report from him but she did not discuss it with him. He reported that he had issues in the mailroom and had to leave early. Ms. Cowell testified that Petitioner has not been back to work since February 25, 2015.

The Arbitrator concludes:

Issue (C) Accident.

Petitioner sustained an accident on September 29, 2014. Petitioner's account of the accident is unrebutted and corroborated by the accident reports.

Respondent's third party administrator, TriStar, denied Petitioner's claim in early March of 2015 for the reason Petitioner's accident did not arise out of or in the course of his employment. While not a part of the record, Respondent's proposed decision addressed neither of these elements. Instead, it argued Petitioner did not sustain an accident because Petitioner's testimony was not credible in that his alleged accident was unwitnessed, did not result in the need for any medical treatment for approximately one month during which time Petitioner worked full duty until he went out on a previously scheduled leave of absence, and when he did seek medical treatment he immediately went to Dr. Gornet rather than his family doctor, Dr. Keele.

To begin with, Petitioner was a very credible witness regarding the accident and he answered all of the questions posed to him in a direct and forthright manner. While Petitioner may not have sought treatment for a month and did work some during that time, he credibly explained how his symptoms were escalating and his condition deteriorating. Furthermore, in his Incident Report of October 26, 2014, Petitioner stated that he advised his supervisor, Lt. James Powell, on October 26, 2014 of the accident. That testimony was unrebutted. While Respondent may question how Petitioner could work full duty for four days and then assist his ill friend with doctor's visits for approximately 28 days before seeing a doctor but was later unable to work light duty with a five lb. restriction, that particular question was never posed to Petitioner directly. It should also be noted that Respondent produced no witnesses to rebut Petitioner's testimony regarding the job duties he had in the mail room.

Petitioner consistently described the events of September 29, 2014 and thereafter at trial, in his Incident Report, and to his physicians. No one questioned Petitioner's veracity. At the time of the accident Petitioner was in the course of his duties. He had clocked in (roll call – RX 3) and was reporting to the tower, one of his job duties. As part of those job duties he was required to close the hatch once up there. This task was distinctly related to his employment. Even if the movement is arguably a common movement made by the general public, it still arises out of employment if the employee is engaged in work-related activities at the time the accident occurred. The Arbitrator notes, however, that both the location of the door, the type of the door Petitioner had to open, and the frequency with which he ws required to open it, removed his accidental injury from the realm of a "neutral risk." The door is large, awkward and heavy in appearance, located in the floor, and opened with a leather strap. It clearly is not a door which confronts members of the general public. Opening this door posed an increased risk of injury.

Petitioner understandably turned to Dr. Gornet rather than Dr. Keele for treatment as the former was familiar with his neck and back from prior treatment and that is where Petitioner's symptoms were emanating from.

Based upon the foregoing, the Arbitrator concludes that Petitioner sustained an accident on September 29, 2014 that arose out of and in the course of his employment with Respondent.

Issue (F) Causal Connection.

Petitioner's current condition of ill-being is causally connected to his September 29, 2014 accident.

Petitioner's treating physician, Dr. Gornet, and Respondent's § 12 examiner, Dr. Petkovich, both agree that Petitioner suffered some injury as a result of the September 29, 2014 work accident. (PX3; RX5) While they disagree on the nature of the injury, the Arbitrator finds this dispute to be immaterial. Dr. Petkovich agreed in his February 2015 report that Petitioner had not reached maximum medical improvement and conceded that he could not give an estimate as to such date because it would "depend on Petitioner's response to further evaluation and treatment." (RX5). Additionally, Dr. Petkovich did not specifically address the annular tear which Dr. Gornet had diagnosed and causally connected to the work accident. The Arbitrator also notes that the subsequent events of February 25, 2015 resulted in a set-back of sorts with respect to Petitioner's condition of ill-being. However, that set-back stems from this accident and did not break the chain of causation. The Arbitrator finds the causation opinion of Dr. Gornet to be persuasive in this instance and agrees that the accident that occurred on September 29, 2014 is the accident which led to Petitioner's current condition of ill-being. In support of this finding, the Arbitrator notes that Petitioner credibly testified that he sustained no other injuries to his low back, did not require any low back treatment, and did not take any narcotic medication for his low back between the time he settled his prior injury in 2010 and his accidental injury in September of 2014. Since the accident on February 29, 2014 Petitioner has never been released to full duty work nor has he been deemed at maximum medical improvement.

The Arbitrator notes some concern over the events of February 25, 2015 and Petitioner's representations and histories given thereafter. For example, in his Incident Report he focused on walking activities and bending with his neck. However, the ER note focuses on Petitioner's low back. Furthermore, Petitioner never mentioned the incident to Dr. Grandberg when receiving injections. Also,

Dr. Keele's actual office visit from March of 2015 isn't a part of the record. Finally, Petitioner misled Dr. Gornet as to the type of work he had returned to in February of 2015 and told the doctor it was bending at the waist that bothered him and nothing about walking. Despite these inconsistencies, causation appears intact and the discrepancies go more to the issue of TTD dates which Respondent did not dispute. Even with these inconsistencies Petitioner's condition in his low back had not plateaued and his condition during the time of his attempted return to work remained causally connected to the accident.

Issue (J) Medical Expenses.

Consistent with her liability determination set forth above, the Arbitrator finds that all of Petitioner's care was necessary and reasonable. Both Petitioner and his physician wish to avoid further surgery. (PX3, 6/8/15). Accordingly, the injections and prior conservative care are clearly reasonable. Petitioner is awarded his medical bills as found in PX 1 (totaling $42,842.84) subject to the medical fee schedule and with Respondent receiving credit for any and all bills previously paid.

Issue (L) Temporary Total Disability Benefits.

Respondent did not dispute the dates of temporary total disability, only liability for them. Consistent with her liability determination set forth herein, Petitioner is awarded temporary total disability benefits from October 31, 2014 through February 23, 2015 and February 26, 2015 through the date of hearing, July 30, 2015, a total of 38 3/7 weeks. Respondent paid temporary total disability benefits in the amount of $13,234.71 and Petitioner received 5 service connected days for which it shall receive credit as stipulated between the parties. (AX 1)

Issue (L) Maintenance and (O) Other -Vocational Rehabilitation.

With regard to maintenance and vocational rehabilitation, the Arbitrator notes that Petitioner has not yet received his permanent restrictions. Whether or not Petitioner will be able to return to work for Respondent is not known at the present. He is to return to see Dr. Gornet in late August. What will transpire at that visit is purely speculative at this time. Accordingly, these issues are premature and moot at this time and neither is awarded.

****

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

Gregory Ingle,
Petitioner,

vs.

Knox County Landfill,
Respondent.

16IWCC0424

NO: 13 WC 37837

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 16, 2015, is hereby affirmed and adopted.

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

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

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

DATED: JUN 2 2 2016
o6/7/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0424

INGLE, GREGORY
Employee/Petitioner

Case# 13WC037837

KNOX COUNTY LANDFILL
Employer/Respondent

On 9/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.26% 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:

1824 STRONG LAW OFFICES
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3100 N KNOXVILLE AVE
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5240 BUSH MOTTO CREEN KOURY ET AL
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16IWCC0424

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

GREGORY INGLE
Employee/Petitioner
v.

KNOX COUNTY LANDFILL
Employer/Respondent

Case # 13WC 37837

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS MCCARTHY** Arbitrator of the Commission, in the city of **Peoria on July 24, 2015.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

O. ☐ Other

16IWCC0424

FINDINGS

On **7/8/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$38,532.00**; the average weekly wage was **$741.00**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **no** dependent children.

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

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

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

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

ORDER

PETITIONER HAS FAILED TO PROVE AN ACCIDENTAL INJURY ARISING OUT OF HIS EMPLOYMENT CAUSALLY RELATED TO HIS CONDITION OF ILL BEING. THE CLAIM IS DENIED.

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

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

D. D. McCarthy
Signature of Arbitrator

Sept. 10, 2015
Date

SEP 16 2015

FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim against Respondent alleging that on July 8, 2013 he sustained injuries to his right and left hands. (PX 1) Petitioner testified that he worked for the Knox County Landfill for 24 years. He worked as a heavy equipment operator until 2001, when he became Superintendent of the Landfill.

Petitioner introduced photographs showing pieces of heavy equipment at the Landfill and two trucks and some tools at the Landfill. Petitioner described his use of the heavy equipment he operated as 815 Dirt Compactor, in the summer mainly and had last operated in 2012, CATD7R Dozer, on a weekly basis, John Deere Backhoe, used quite a bit during the first half of employment, CAT621G Scraper, used quite a bit, CAT140H Maintainer, one to two times per month, Deere Articulated Loader, did not operate often, Vermeer Tub Grinder, no testimony as to how often, CAT826G Garbage Compactor, used first half of career quite a bit, and Case 445CT, no testimony as to how often. Petitioner drove a hauling truck with power steering quite a bit.

Petitioner testified he operated the above-described equipment on a daily basis. On cross-examination, he testified he did not operate heavy equipment or use tools on a day-in-day out basis for over half a workday since becoming Superintendent in 2001.

During the last few years of his employment Petitioner was mostly in the office being in the office for more than four (4) hours a day. Petitioner did daily computer work. Mr. Reynolds testified the computer work consisted of answering e-mails, looking for parts and filling out monthly landfill reports to the EPA, which would have taken about an hour.

Jerry Reynolds, the Landfill Administrator since 2008, testified that the Superintendent's position is a management position and the Landfill has been unionized since 2004 or 2005. Heavy equipment operators and mechanics are union positions. Since Petitioner became Superintendent, the Landfill has employed six (6) full time heavy equipment operators and one (1) mechanic.

Mr. Reynolds testified that there was a union contract, in effect since 2004 or 2005, which prohibited management from performing union employee's jobs, except in emergency situations or when a union worker was not available. (RX 10) Petitioner testified that this rule did not apply to him. Mr. Reynolds testified that the rule did apply to Petitioner. Bob Wagher, the Landfill Yard Foreman, testified that the rule was enforced at the Landfill. There is no language in the union agreement excepting Petitioner from that rule.

Mr. Reynolds testified that Petitioner operated pieces of heavy equipment in emergency situations and when there were no available operators. He went through each piece of equipment identified in the photographs, testifying that there were certain of those machines he had never seen Petitioner operate and others that he had seen Petitioner operate six to twelve times over the eight year period he had been Administrator. Mr. Reynolds further testified Petitioner did not operate the heavy equipment on day-in-day out basis for over half a work day during any of the time since he had been Administrator.

Mr. Wagher had been with the Landfill since 2002, first as a heavy equipment operator and then as Yard Foreman. He went through the equipment pictured in the photos and testified that Petitioner operated a number of the machines pictured, but his operation of those machines was sporadic and for short periods of time.

Petitioner did not operate the heavy equipment or use the tools pictured on a day-in-day out basis for over half a work day during any of the time he was employed by the Landfill.

The photographs depicting the machines Petitioner claimed he operated show most of those machines were controlled using joysticks. (PX 12) His wrists as shown in the photos are not in a 45 degree flexed or awkward positions. (PX 12)

Petitioner saw Dr. Hershkowitz on February 8, 2008 with carpal tunnel symptoms in his right and left hands, the right being worse than the left. (RX 3) He saw Dr. Nikolov on February 20, 2008 with reports of hands fall asleep and pain in wrist to elbows. (RX 4) Petitioner did not tell either Dr. Hershkowitz or Dr. Nikolov that he believed his carpal tunnel symptoms were related to work and mentioned nothing about his work activities. Neither Dr. Hershkowitz nor Dr. Nikolov causally connects Petitioner's carpal tunnel to his work at the Landfill. Petitioner did not report a work related injury to his hands to the Landfill either before or after seeing Dr. Hershkowitz or Dr. Nikolov.

Dr. Nikolov performed an EMG/NCV study on February 20, 2008 which showed mildly abnormal with evidence of median focal neuropathy at the wrist (CTS) bilaterally and worse on the right. The history was a 44 year old male presents with numbness with hands.

Petitioner had no further treatment for carpal tunnel symptoms over the next five years. On August 5, 2013 Petitioner saw Dr. DeYoung with a report of hands tingle and fingers, no grip, pain in palm and thumbs. (RX 9) Dr. DeYoung's diagnosis was mixed hyperlipidemia and carpal tunnel syndrome. He was seen by Dr. Nikolov on August 6, 2013 at the request of Dr. DeYoung with complaints of bilateral wrist pain and pain in the palms of the hands. (RX 5) His symptoms were several years old. (RX 5)

Dr. Nikolov did an EMG/NCV study on August 9, 2013 which revealed evidence of bilateral median focal neuropathy at the wrist (CTS) mild on the right and moderate on the left. Petitioner was sent for x-rays of his right and left hands by Dr. Nikolov on August 9, 2013 with a history of 49-year-old patient with a history of no known injury, chronic bilateral hand pain. The x-rays showed osteoarthritis of both hands. Dr. DeYoung referred Petitioner to Dr. Mahoney at Midwest Orthopedic Center for evaluation.

Dr. Mahoney saw Petitioner on August 20, 2013, giving a history of several years ago had some symptoms of CTS, had testing at that time which was relatively mild, both hands. (RX 6)

Petitioner did not relate his carpal tunnel symptoms to his work at the post-accident visits with Dr. DeYoung, Dr. Nikolov or Dr. Mahoney. Nor did he not mention anything about his work activities at those visits. Neither Dr. DeYoung, Dr. Nikolov nor Dr. Mahoney causally connects Petitioner's carpal tunnel to his work activities. Petitioner did not have any carpal tunnel symptoms before 2001, when he was a heavy equipment operator at the Landfill. He did not report a work related injury to his hands at any time from 2001 to 2012.

Dr. Rhode was the only physician who casually connected Petitioner's carpal tunnel to his work. On cross-examination, Dr. Rhode admitted he relied on the Job Description Form provided by Petitioner for what he did with his hands, wrists and arms and how often during a workday he did them. (PX, p. 42) Dr. Rhode based his causal connection opinion on the description provided in that Form. (PX, pp. 42-43) The form contained questions concerning which job duties required the Petitioner to use his hands and the frequency of hand use on each of the machines he used. The Petitioner did not answer those questions on the form.

Dr. Rhode was under the impression Petitioner had been operating heavy equipment and using tools for the past 24 years for more than half the workday each day. (PX 11, pp. 31 & 46-47)

Dr. Rhode agreed before making a determination as to whether or not carpal tunnel or an injury is work related, it is helpful to review the records closest to the work accident and before the work accident. (PX 11, pp. 31-32) He was not provided with the photos showing the heavy equipment, trucks and tools until he gave his testimony on March 12, 2015, which was after he opined Petitioner's carpal tunnel was related to his work. He did not recognize Petitioner in the photos.

Petitioner was examined at Respondent's request on September 13, 2013 by Dr. Monaco. Dr. Monaco testified carpal tunnel in the majority of cases is not work-related and not occupational, often idiopathic, and more strongly related to non-occupational factors, such as obesity, diabetes, age and other co-morbid diseases such as arthritis. (RX 2, pp. 23-24) Petitioner told Dr. Monaco his work at the Landfill was as a heavy equipment operator and mechanic for a period of 23 years. (RX 2, p. 13) He indicated this involved operating machinery, such as a backhoe, bulldozer, tractors and trucks. (RX 2, p. 13) He asked Petitioner to describe specifically what his job duties consisted of at the Landfill and assumed that he was given a complete and accurate description of all of what Petitioner did at the Landfill. (RX 2, p. 54) Petitioner did not mention any hand tools that he used. (RX 2, p. 55)

Dr. Monaco testified that Petitioner did not report any continuous repetitive activities involving the hands and wrists. (RX 2, p. 22) He indicated that he did note some vibration in his hands around the steering wheel of some of the heavy equipment. However, Dr. Monaco testified that the medical evidence does not support vibration alone as a cause of carpal tunnel. (RX 2, p. 45) He further testified that the usual combination of risk factors which precipitate carpal tunnel are a combination of force and repetition or of force and posture. (RX 2, p. 22) Dr. Monaco found no problems with the posture in the sense that Petitioner did not have to use his hands in awkward positions which basically involved more than 45 degrees of flexion and more than 45 degrees of extension. (RX 2, pp. 22-23) None of his job duties with heavy equipment involved continuous excessive force or posture. (RX 2, p. 23)

Dr. Monaco concluded, within a reasonable degree of medical and surgical certainty, that Petitioner's carpal tunnel was unrelated to his job duties and that his condition was not aggravated by his job duties at the Landfill. (RX 2, pp. 23-24)

Dr. Monaco supported his conclusion with a newsletter from the AMA for May to June 2009, which indicated there were a relatively small number of jobs where high force and repetition were present and that the literature to that point and currently is there is not good medical evidence as far as causation in regards to work-related activities causing carpal tunnel other than the combination of force and posture or force and repetition. (RX 2, p. 25) He cited the AMA Guides to the Evaluation of Disease and Injury Causation which found that non-occupational factors such as obesity and aging are strong factors in regard to causation of carpal tunnel. (RX pp. 28-29)

CONCLUSIONS OF LAW

It is Petitioner's burden of proof to establish repetitive trauma injuries to his right and left hands as a result of his work activities and his condition of ill-being is causally related to the alleged accident.

Petitioner did not quantify how often and for how much time during a workweek he actually operated heavy equipment or tools. For example, he testified in response to his attorney's questions that he operated heavy

equipment on a daily basis, however, on cross-examination, he said he did not operate heavy equipment or use tools on a day-in-day out basis for over half the workday since becoming Superintendent in 2001. He also presented no evidence to corroborate his claim that, as a working supervisor, union rules prohibiting him from performing union work did not apply.

Mr. Reynolds and Mr. Wagher, the Landfill Administrator and Yard Foreman, establish that Petitioner's operation of heavy equipment was sporadic and did not occur on a day-in-day out basis for over half a workday since he became superintendent in 2001. Mr Reynolds and Mr. Wagher provided different perspectives on Petitioner's use of heavy equipment and tools as one was in charge of the Landfill and the other out in the yard.

The photographs submitted by Petitioner show most of the equipment controls were joystick operated and did not involve his hands being in 45 degrees of flexion or other awkward positions that are associated with developing carpal tunnel. The two trucks which were shown in those photographs have power steering. Petitioner provided no testimony or evidence to contradict what is shown in the pictures.

Neither Dr. Hershkowitz, Dr. Nikolov, Dr. DeYoung nor Dr. Mahoney causally relates Petitioner's carpal tunnel to his work. In fact, Petitioner did not mention to any of these physicians his work as a cause of his condition and did not mention his work activities at all. Petitioner saw all of these physicians before seeing Dr. Rhode and none of them related his carpal tunnel condition to his work.

In a case like this, the medical testimony and opinions are of significant importance and the medical expert must have a clear and accurate understanding of the Petitioner's work in order for his opinion to carry any weight. Dr. Rhode is the only physician who causally connects Petitioner's carpal tunnel to his work. It is clear Dr. Rhode did not have an accurate understanding of Petitioner's job duties involving the use of his hands, wrists or arms or how often he did those duties.

The problem with Dr. Rhode's testimony is that it is based on inaccurate and incomplete information. Dr. Rhode agreed that in determining whether carpal tunnel syndrome is caused by repetitive activities at work, it is important to know the job duties that the person performed that involved the use of their hands, wrists and arms, and how long in the course of a workday the person uses their hands, wrists and arms and in what fashion they are using them. (PX 11, p. 41) In the Job Description Form Petitioner provided to him and he relied upon for his causal connection opinion, the two questions asking about job duties that required the use of his hands, wrists and arms and the repetitions per minute, per hour and per day, Petitioner did not answer. (PX 11, p. 42-44) That lack information undercuts his causal connection opinion. Dr. Rhode's understanding was Petitioner was operating said machinery for more than half the workday for the last 24 years. (PX 11, p. 46-47) That understanding is not accurate based on Petitioner's own testimony and the testimony of Mr. Reynolds and Mr. Wagher

Petitioner did not tell Dr. Rhode that he changed jobs at the Landfill in 2001, when he went from operator to Superintendent. (PX 11, p. 56) In fact, Petitioner told Dr. Rhode that he had been a mechanic for his current employer for the past 24 years. (PX 11, p. 56-57) Petitioner did not tell Dr. Rhode that his job duties significantly changed after he became Superintendent in 2001. (PX 11, p. 57) Petitioner went from being an operator to management wherein his job was no longer to operate heavy equipment or use tools, except in emergency situations. Both Mr. Reynolds and Mr. Wagher testified after Petitioner became Superintendent he was not operating heavy equipment on a day-to-day basis and was not doing so for over half a workday.

Dr. Rhode conceded on cross-examination that if the information relayed to him by Petitioner about his job title and duties involving the use of his hands, wrists and arms and the duration of those job duties and activities outside of work and the past medical history were inaccurate it could negatively impact his causal connection opinion. (PX 11, p. 57)

The Arbitrator finds that the Petitioner has failed to prove that he sustained a repetitive trauma injury to his right and left hands as a result of his as Landfill Superintendent for the Knox County Landfill or that said condition of ill-being is causally related to the alleged accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brad Grossman,

Petitioner,

vs.

NO: 14 WC 27522

ProTek Construction, LLC,

16IWCC0425

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 12, 2015, is hereby affirmed and adopted.

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

16IWCC0425

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

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

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

DATED: JUN 2 3 2016
TJT:yl
o 6/21/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

GROSSMAN, BRAD
Employee/Petitioner

Case# **14WC027522**

PROTEK CONSTRUCTION LLC
Employer/Respondent

16IWCC0425

On 8/12/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0659 BRILL & FISHEL PC
FRANCINE R FISHEL
180 N LASALLE ST SUITE 3700
CHICAGO, IL 60601

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Brad Grossman
Employee/Petitioner

v.

ProTek Construction, LLC
Employer/Respondent

Case # 14 WC 27522

Consolidated cases: _____

16IWCC0425

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 10, 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 **$99,999.64**; the average weekly wage was **$1,923.07**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **2** dependent children.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,282.05** week for **53** weeks, commencing **July 11, 2014** through **July16, 2015**, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$139,077.79** as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

8/11/15
Date

AUG 12 2015

16IWCC0425

FINDINGS OF FACT

This case involves a Petitioner who alleges injuries due to falling off a roof on July 10, 2014. (Arb. Exh. 2) The primary issue in dispute is whether the Petitioner's injuries arose out of and in the course of his employment with the Respondent. The parties stipulated at the onset of this hearing to the following issues: 1) accident, 2) causation, 3) average weekly wage, 4) medical expenses, and 5) TTD. (Arb. Exh. 1)

Petitioner Brad Grossman testified that he was hired by Respondent ProTek Construction as a salesman in April 2014. ProTek is a company that does roofing and siding repair. The company specializes in roof replacements for storm-damaged homes. Petitioner's job required him to go into storm-damaged neighborhoods and sell roofing repair jobs. He was an experienced salesman and had been specializing in this type of sales for a number of years. He explained that he was able to successfully sell these roofing repair jobs because he had a good reputation and good client referrals.

On or about July 1, 2014, Petitioner received a call from a woman who asked Petitioner to go out to her brother's home because he needed help with his roof. Petitioner recalled that the caller had a heavy accent. Petitioner went to the address that she gave him, where a man was standing outside. The homeowner, who had been waiting for someone to inspect his roof, directed Petitioner to the roof. On inspection, Petitioner noted that there was minimal damage. He advised the homeowner not to make a claim with his insurance company. While talking to the homeowner, Petitioner realized that the homeowner had been waiting to meet someone else to inspect his roof. He had been misdirected and he had gone to the wrong home.

Petitioner testified that there were other people in the neighborhood who saw him on the roof, and they asked him to inspect their roofs as well. Petitioner inspected a second roof, which was worse than the first and had damage on all four sides of the roof. The homeowner told him they were just sitting down to dinner, so Petitioner gave him his business card and told the homeowner to call him in the next few days and he would start the process for him.

Petitioner then inspected a third roof at the next door neighbor's request. This roof was not badly damaged, and he did not think that a claim should be filed.

Petitioner testified that he then received a call from the woman who had previously called about her brother's house. Petitioner told her that she had given him the wrong address. At that point, she gave him the correct address, and he proceeded to the fourth home on the street. The homeowner did not speak English, and thus his son acted as interpreter. Once on the roof, Petitioner observed that the entire rear facet, or rear slope, of the roof was destroyed. He explained to the homeowner that he could place a tarp on the roof to protect the home from rain or animals. Petitioner testified that he typically offered to place a tarp on the roof in circumstances such as these. The homeowners agreed and the next day Petitioner returned to the house to cover the damaged portion with a tarp.

On July 9, 2014, the homeowner called Petitioner to let him know that the adjuster from the insurance company was coming to inspect his roof the next morning. The son told him that the insurance company wanted the tarp removed before the inspection. Petitioner wanted to remove the tarp that evening, but the homeowner asked him to leave it on overnight. Accordingly, Petitioner went to the home in the early morning of July 10, 2014. He went up onto the roof to remove the tarp in preparation for the insurance inspection. He testified that the tarp must have been wet and he slipped and fell off the roof. He did not remember the events immediately following his fall. Petitioner's medical treatment will be discussed further in this decision.

Petitioner testified about how he handled his sales calls. He stated that he does not always ask a prospective client to sign a contract for the roof repair immediately after the initial inspection. He explained that he uses his intuition. He stated that he does not want people to feel pressured to sign a contract. In this particular instance, in a situation involving a half of a roof, he waited to see what the adjuster was willing to pay towards the roof repairs. He stated that he could then write a work order and bid for the remaining part of the roof. He testified that in his experience he was able to establish good client relations and had return business as a result of his sales practices.

On cross examination, Petitioner reiterated that he does not always sign the homeowner to a contract at the time of the first meeting. He does it, "when I feel it's the right time or when we can meet up." He again explained that in general he does not always sign a contract with the potential client when it is not obvious that a full roof replacement is needed. He also explained that he does not want to have a client sign a contract because if they sign and then decide to go with another company there is a cancellation fee. He stated, "It just turns into a mess, you know, they didn't understand the contract." He further stated, "This was kind of one of those times where because of the language barrier I didn't want this to become one of those where they come back saying, you know, my father didn't understand..." He testified that he wanted to avoid a misunderstanding.

Petitioner testified that he spoke with his supervisor, Brian Roter, many times a day. He testified that the first evening he was in this particular neighborhood he called Roter from the first roof he inspected. This was the house that he went to by mistake because he was misdirected by the female caller. He testified that he told Roter that he had found a new area for work, referring to it as a "honey hole." Petitioner explained that a "honey hole" is an area in which the salesperson can solicit jobs on foot. It is an area that they would not have known about had they not been directed to the neighborhood. He testified that Roter understood what he meant and in fact told him that he would send other "guys from the company" because it was a "good area."

Petitioner was asked whether he had done any roof repairs or side jobs while working for Respondent and he answered "absolutely not." Petitioner testified that he had no intention of doing this job on his own.

Testimony of Sinh Huynh - The homeowner

Mr. Sinh Huynh testified on behalf of Respondent with the assistance of an interpreter. Mr. Huynh was the homeowner at the residence where Petitioner fell. He testified that his sister-in-law contacted Petitioner on his behalf and asked him to inspect his roof after a storm. The witness identified Petitioner as the person who had come to his home. He also stated that his son acted as interpreter for him. The witness testified that he did not know of a company called ProTek Construction and had not signed a contract with that company. The witness stated that Petitioner came back and put a cover over his roof. The witness further stated that he called Petitioner and asked him to come back. He testified that Petitioner "fell down." He stated that the work on his roof was done by another company.

Mr. Huynh further testified that Petitioner gave him a card to call him. Though at first he did not recall if the business card was from ProTek Construction, when shown the actual business card he confirmed that it was the card that Petitioner gave him. (Pet. Ex. 14) Mr. Huynh also recalled that Petitioner was wearing a shirt with the name ProTek on it. The homeowner testified that he called Petitioner and asked that he come back to his home. He confirmed that this was the third time he was at the home. He also testified that Petitioner fell before the insurance adjuster arrived at his home. The witness testified that eventually his roof was repaired by another company. He explained that the insurance company paid for some of the repairs to the back roof and he paid the remainder.

Testimony of Brian Roter

Respondent called Brian Roter to testify on its behalf. Mr. Roter explained that he had been with the company over one year and they started the business in March or April of 2014. He stated that his job was operations manager. He explained that ProTek targets areas of storm damage. He further explained that they work with the client and the insurance company to "maximize the claim..." He stated that they send out flyers, canvass the neighborhood and send out a salesperson if they get a call. He testified that the salesperson goes to the client, explains what they do and works with the client to file an insurance claim. Mr. Roter stated that the salesperson inspects the roof, takes pictures, and then meets with the homeowner to discuss the damage. Mr. Roter testified that at that point the salesperson presents the homeowner with a contract. If the homeowner does not sign, he "typically" would not continue to work with the client because there is a chance they could use another contractor.

Mr. Roter was asked if the salesperson would furnish or buy tarps to put over roofs and he answered "Typically not." On second thought, he then stated, "If you're on the roof and you see it's going to leak you would, yeah."

Mr. Roter was also asked if the salesperson would sign the homeowner to a contract before or after the tarp is placed on the roof. He responded that "usually" they sign, but "there are instances where the client is not home", and "if it's going to leak into the guy's home, you're going to put a tarp on there whatever..."

Mr. Roter testified that he knew Petitioner well and that they had worked together at a different storm restoration company called Safeguard Construction for five or six years.

Mr. Roter recalled the telephone conversation that he had with Petitioner before the 4th of July. He could not recall the exact date. He testified that Petitioner asked him if they had time for repairs, and he told Petitioner that they were booked and too busy to deal with repairs at that time. He also recalled that Petitioner asked him if he would be interested in working with him to do a "quick repair" and he also said that he answered, no, that he was too busy. Mr. Roter testified he himself is a carpenter by trade, and he had done skylight replacements and roof repairs. He stated that he did one job with Petitioner while working at Safeguard, which involved a hip and ridge shingle replacement.

Mr. Roter stated that Petitioner was a "pro" when it came to sales. He was asked to comment on Petitioner's Exhibit 16, a compilation of contracts that Petitioner signed up for ProTek. Mr. Roter stated that he had signed "a lot of work" in a very short period of time and the work was "successful." He testified that he trusted Petitioner to do his job and trusted his judgement. He stated Petitioner had a good relationship with his clients and he agreed that Petitioner had a lot of repeat business. When asked, "And so based on his experience you trusted him to do the right thing for the client at the right time, isn't that true?" Roter answered, "Yep".
Mr. Roter was then asked again about the conversation he had with Petitioner. "When he called you this conversation we talked about doing repairs and you said you didn't have any time for that? Mr. Roter indicated that when Petitioner asked him whether he had a time to do a "quick repair," or a minor repair, it was possible that Petitioner may have been referring to a house different from the one he had fallen from.

Mr. Roter also confirmed that Petitioner was not a roofer and that the repair of half of a roof would not typically be a "quick repair" or a minor repair. Mr. Roter explained that the scope of the work may change after the initial roof inspection by a salesperson. He stated, "You don't know what the adjuster is going to approve right there because every adjuster is a little different."

16IWCC0425

Medical Treatment

On July 10, 2014, Lockport Fire Protection District EMT, Patrick Kelly, found Petitioner lying on his left side on the wooden deck at 14060 South Lakeridge Drive, Romeoville, Illinois 60446 (Pet. Ex. 11). Petitioner was subsequently brought to Bolingbrook Hospital where he was found to be non-verbal.

Petitioner was then transferred by Superior, via helicopter, to Loyola University Medical Center due to his worsening medical condition and a Glasgow Coma Score (GSC) of 7. Petitioner was admitted into Loyola University Medical Center with "fractured ribs, fractured left ankle, fractured left clavicle, fractured pelvic bone, left eye gaze palsy, small intracranial hemorrhage and concussion" (Pet. Ex. 1A & B). Petitioner remained inpatient at Loyola University from July 10, 2014, until July 16, 2014.

On July 18, 2014, Petitioner started rehabilitation therapy for his traumatic brain injury (TBI) at Rehabilitation Institute of Chicago (RIC) at NorthShore. Petitioner's treatment consisted of an inpatient program at Advocate Lutheran General Hospital from July 30, 2014, through August 6, 2014 (Pet. Ex. 5).

From August 7, 2014, through February 13, 2015, Petitioner continued with outpatient physical and vocational therapy program with Dr. Susan Lis from Advocate Medical Group at RIC for his TBI (Pet. Ex. 2 A & B, Pet. Ex. 8, Pet. Ex. 9).

On September 10, 2014, Petitioner sought treatment with his primary care physician, Dr. Jefferson Schott, at NorthShore University Health Systems. Petitioner was diagnosed with depression, and was advised to continue with his treatment for his TBI. Petitioner was referred to a Neurologist for an evaluation and was recommended to continue his therapy with Dr. Susan Lis (Pet. Ex. 9).

On September 30, 2014, Petitioner saw neurologist, Dr. Wayne Rubinstein, at Advocate Medical Group for numbness on the left side of his body (Pet. Ex. 9). Dr. Rubinstein recommended that the Petitioner continue with regular therapy sessions with Dr. Susan Lis as well as continue with follow up care with his office. Petitioner's treatment with Dr. Rubinstein is still ongoing (Pet. Ex. 9).

Petitioner continues to treat for his cognitive and physical impairments with Dr. Susan Lis at Advocate Medical Group (Pet. Ex. 9).

On November 20, 2014, Petitioner was referred to an Orthopedic Surgeon, Dr. Arif Ali, for his complaints of pain from the left pelvic facture and left shoulder pain. Dr. Ali recommended a course of conservative treatment consisting of in-office injections and outpatient physical therapy for his "separate shoulder as well as likely subacromial bursitis". Dr. Ali also modified Petitioner's activity level to improve the pain in his hip. Dr. Ali recommended follow-up appointments to monitor his progress (Pet. Ex. 7). From November 20, 2014 through January 29, 2015, Petitioner continued to treat with Dr. Ali (Pet. Ex. 7).

From March 18, 2015, to present Petitioner continues with his recommended physical therapy program for his left shoulder pain and function improvement of his left lower extremity at Rebound Fitness (Pet. Ex. 6)

Section 12 Medical Exams

On March 4, 2015, Petitioner attended a Section 12 examination with Neurologist Dr. Alan Shepard at Northwestern Medicine (Resp. Ex. 1). Dr. Shepard's diagnosis was: postconcussive syndrome with

intracerebral trauma as well as neck and back and some mild cognitive dysfunction. Dr. Shepard's report indicated, "His cognitive function appears to be improved, but certainly I would want the neuropsychologist also to determine that cognitively he would be able to be working normally. These restrictions are causally related to his fall on July 10, 2014." Dr. Shepard recommended sedentary work consisting of sitting at a desk, answering the telephones and walking short distances.

On March 27, 2015, Petitioner attended a Section 12 examination with Psychologist Dr. Ronald Ganellen (Resp. Ex. 2). Dr. Ganellen diagnosed Petitioner with Adjustment Disorder which "apparently developed in response to the effects of the 4/10/15(*sic*) accident." Dr. Ganellen noted, "The primary issues that affect his return to work involve his physical capabilities, such as changes in balance, dizziness, and a tendency to tire more quickly than in the past."

Average Weekly Wage

Petitioner submitted a document labeled ProTek Construction Commission Structure to support calculation of his earnings. (Pet. Ex. 14). The document stated as follows:

"Brad shall receive 40% of Contract Profit less Overhead Charge (CPOC) for revenues received by the Company."

Petitioner also offered an exhibit with multiple documents labeled ProTek Construction, LLC Commission Payout. These documents indicate the CPOC monies received by Respondent for each agreement or contract that Petitioner signed on behalf of Respondent (Pet. Ex. 15). Petitioner's documents indicate that his sales generated $232,903.18 in CPOC monies for Respondent. Petitioner calculated that he would have been entitled to $93,161.27 in commissions per the ProTek Construction Commission Structure.

Petitioner also submitted copies of the signed agreements he obtained for work on behalf of Respondent (Pet. Ex. 16).

TTD & Medical Bills

Petitioner testified that to date he has not received any monies for Temporary Total Disability by the Respondent. He also testified that his wife's group insurance has been paying his medical bills.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to (C), did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator concludes as follows:

The primary issue in this case is whether Petitioner's fall on July 10, 2014 arose out of and in the course of his employment with Respondent. Respondent is disputing this issue based on its theory that the Petitioner was injured when he may have been performing a side job or a job that was outside of his employment with Respondent. In support of Respondent's theory, it argues that because there was no contract signed by the owner of the home where Petitioner fell, the Petitioner's fall was not related to his employment. Respondent also brings up the fact that the Petitioner was paid $300.00 in cash from the homeowner, which he did not report to the Respondent, which further show that all Petitioner's efforts at the time of his accident was not related to his employment. And finally, since the Petitioner knew that the Respondent would not be interested in half roof

repair job, and the home from which he fell was a half roof repair job, Petitioner's efforts in putting a tarp on the roof, went beyond the scope of his employment. While all of these arguments present a strong argument, they are not completely persuasive on this issue.

An accident is compensable only if it arises out of and in the course of employment. "For an injury to 'arise out of the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incidental 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." Cox v. IWCC., 406 Ill. App. 3d 541 (2010) citing, Caterpillar Tractor Co. v. Industrial Comm'n., 129 Ill. 2d 52,58 (1989). "In the course of employment refers to the time, place, and circumstances under which the claimant is injured. Scheffler Greenhouses, Inc. v. Industrial Comm'n, 66 Ill. 2d 361, 366, (1977). Injuries sustained at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." Id. citing Caterpillar Tractor Co., 129 Ill. 2d at 57.

The Arbitrator finds that Petitioner's injury arose out of and in the course of his employment with Respondent. In support of this finding, the Arbitrator relies on the Petitioner's credible testimony, which was not rebutted regarding the circumstances surrounding the accident. At the site of the accident, Petitioner presented himself as an employee of Respondent by wearing a shirt with the company's name and giving his company's business card, all of which was confirmed by Mr. Huynh, the owner of the home where Petitioner fell. Mr. Huynh contacted Petitioner by calling him on the business card, which indicated the name of the Respondent. There was no evidence introduced at trial that Mr. Huynh believed he was dealing with Petitioner as someone who was working outside of Respondent. Given the language barrier between Mr. Huynh and the Petitioner, the Arbitrator finds it credible that the Petitioner did not present a contract immediately because he did not want to pressure the homeowner into signing an agreement where the scope of the work was undetermined (whole roof vs. half roof); there was a language barrier; and there was a penalty clause in the contract.

Furthermore, the Arbitrator finds credible Petitioner's testimony that his sole purpose of being on the roof was to obtain a contract for his employer. He had no intention of doing this job on his own. Even Respondent's witness, Mr. Roter confirmed that doing such a job was not a minor repair, and that such a job would require a crew. Furthermore, Petitioner is a salesman who by all accounts does not have the skills or experience to do a full roof replacement or even a half roof replacement on his own. This was further confirmed by Respondent's witness.

Respondent denied this case based on their understanding that Petitioner intended to do this job on his own. Apparently, that understanding was based on a single conversation that Petitioner had with his supervisor, Brian Roter. Petitioner called Roter from roof #1 that evening in early July and asked about the possibility of doing a "quick repair." When asked about this conversation, Roter admitted that this conversation might not have applied to the roofing job on roof #4 where he actually fell. The record supports a finding that Petitioner's question about a "quick" repair during that single phone call was answered and the issue was concluded at the end of the call. There were no further discussions and Petitioner never did a single side job while working for ProTek. His testimony was supported by Roter.

Petitioner's act of putting a tarp on the homeowner's roof was a courtesy to the customer and would support the Petitioner's claim that he did not have the homeowner sign a contract because he was waiting to see the results of the inspection by an adjuster to assess the extent of the damage. Brian Roter agreed that it was reasonable and within Petitioner's responsibilities to place a tarp on a damaged roof prior to the insurance inspection. Petitioner also credibly explained that he advanced the money for the tarp and was reimbursed by the homeowner for his expenses.

As the testimony at trial unfolded, it became apparent that Petitioner inspected four different homes in the neighborhood. He was able to observe that there was potential in that neighborhood for a great deal of work for his employer. His supervisor confirmed that he discussed this new potential source of business and both termed the neighborhood a "honey hole." It was reasonable for Petitioner to pursue work in this neighborhood. Clearly, Petitioner is required to inspect many roofs before a contract is signed or an adjuster is even contacted. The Arbitrator also finds that had Petitioner fallen off the roof during any initial inspection, there would have been no accident dispute. His claim should not be defeated because of the timing of the fall.

The Arbitrator finds that Petitioner credibly testified that he had no intention of doing this roof replacement on his own. All of the testimony and evidence adduced at trial support a conclusion that he made every effort to give every client the best possible service for the benefit of his employer. As a salesperson for Respondent, Petitioner was at a place he was reasonably expected to be in the performance of his duties in furtherance of the benefits of his employer. Based on the facts, Petitioner did in fact use good judgment by waiting to present the contract to the homeowner after the insurance inspection. Accordingly, the Arbitrator concludes that given the evidence in the record, Petitioner sustained an accident on July 10, 2014, which arose out of and in the course of his employment with Respondent.

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

Respondent's Section 12 Examiner found a causal connection (Resp. Ex. 1 & 2).
It is also well settled that a causal connection can be also be established solely by providing evidence of a chain of events analysis. Petitioner was working full duty with no restrictions until his accident. Respondent offered no rebuttal evidence in that regard.

Based on the above, the Arbitrator finds that there is a casual connection between the accident of July 10, 2014 and his current condition of ill-being.

In support of the Arbitrator's decision relating to (G), what is Petitioner's average weekly wage; the Arbitrator concludes as follows:

Petitioner's Exhibits No. 15 and 16 reportedly demonstrate an accounting of the contracts Petitioner executed on Respondent's behalf and the commission paid to Petitioner. Respondent's Exhibit No. 3 showed the payments on an anticipated Commission basis to Petitioner.

The commission structure provided Petitioner was to receive 40% of the contract profit minus the overhead charge. It did not provide Petitioner was to receive 40% of the total contract price. The Commission payout statements contained in Petitioner's Exhibit No. 15 indicated the invoiced amount, the job costs, the profit for the job and the overhead. Petitioner's portion was then based on the profit Respondent realized from each job,

which is consistent with the "Commission Structure" provided for in Petitioner's Exhibit No. 14. The Commission was not paid to Petitioner until the job was finalized, invoiced and Respondent collected the amount due under the contact. The commission was not due and owing to Petitioner simply because the contract was signed. Thus, Petitioner did not fully earn or realize the commission for each job before the alleged accident on July 10, 2014.

Pursuant to Section 10 of the Act, the average weekly wage is calculated from the employee's "actual" earnings of the employee during the 52 weeks preceding the date of injury. 820 ILCS 305/10. In this case, Petitioner's Exhibit No. 15 does not represent his actual earnings before the accident of July 10, 2014. It represents contracts signed by Petitioner before the accident, but not his actual earnings before the date of injury. Petitioner's entitlement to and Respondent's obligation to pay the wages did not accrue until the work was completed to the customer's satisfaction, the job was invoiced and Respondent collected under the contract. In fact, the contract itself did not guarantee Petitioner or Respondent the income. Under the contract, the homeowner would not be obligated to have the work completed and Respondent would not be obligated to perform, if the insurance company refused to approve the claim.

Respondent's Exhibit No. 3 therefore represents the actual income earned by Petitioner before the accident on July 10, 2014 and is consistent with an average weekly wage of $1,923.07.

In support of the Arbitrator's decision relating to (J), whether the medical services provided to Petitioner were reasonable and necessary, the Arbitrator concludes as follows:

Based on the above findings with regard to the issues of accident and causation, the Arbitrator finds that Petitioner underwent medical treatment that was reasonable and necessary and causally related to his accident. Petitioner has calculated the medical bills due and owing pursuant to the fee schedule. Respondent is liable for the sum of: $139,077.79

In support of the Arbitrator's decision relating to (L), what amount of compensation is due for temporary total disability; the Arbitrator concludes as follows:

The medical records support a finding that Petitioner was unable to do any work since the date of accident through the date of trial. Respondent's Section 12 examiners concur. Accordingly, the Arbitrator finds that Petitioner was temporarily and totally disabled for 53 weeks from July 11, 2014 through July 16, 2015, and is awarded TTD benefits for that time period.

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

Roberto Cuyugan,

Petitioner,

vs. NO: 12 WC 37878

16IWCC0426

City of Chicago,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 2015, is hereby affirmed and adopted.

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

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

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

DATED: JUN 2 3 2016
TJT:yl
o 6/21/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CUYUGAN, ROBERTO
Employee/Petitioner

Case# **12WC037878**

16IWCC0426

CITY OF CHICAGO
Employer/Respondent

On 4/17/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

4564 ARGIONIS & ASSOCIATES LLC
PHIL GUYETTE
180 N LASALLE ST SUITE 2105
CHICAGO, IL 60601

0010 CITY OF CHICAGO
MICHELLE BRYANT
30 N LASALLE ST 8TH FL
CHICAGO, IL 60602

16IWCC0426

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

Roberto Cuyugan
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **12** WC **37878**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **3/17/2015**. 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 _____

16IWCC0426

FINDINGS

On **6/5/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**73,216.00**; the average weekly wage was $**1,408.00**.

On the date of accident, Petitioner was **65** 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 $**33,525.08** for TTD, $**n/a** for TPD, $**100,338.63** for maintenance, and $**0** for other benefits, for a total credit of $**133,863.71**.

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

ORDER

The Respondent shall pay to Petitioner all unpaid medical expenses as delineated in Petitioner's Exhibit 3, as provided in Sections 8(a) and 8.2 of the Act. The Respondent shall be given a credit for all bills previously paid.

The Petitioner is not entitled to maintenance benefits. Respondent shall receive a credit of $100,338.63 for maintenance benefits paid for the period of February 12, 2013 through March 17, 2015.

The Respondent shall pay Petitioner $695.78 for 150 weeks because the injuries sustained caused 30% loss of use of a person, as provided is 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.

16IWCC0426

FINDINGS OF FACT

The disputed issues in this matter are: 1) causal connection 2) medical services; 3) maintenance; 4) maintenance overpayment; 5) 8d(1) wage differential; and 6) the nature and extent of Petitioner's injuries. *See,* AX1.

Mr. Roberto Cuyugan, ("Petitioner"), testified that he has been employed by the City of Chicago ("Respondent"), as a laborer since 1996 and that on June 5, 2012, while in the course of his employment, he sustained a work-related injury.

Petitioner testified that he does not know his official job title, but knew that he was a laborer. The petitioner testified that his job duties include digging, using shovels and other tools and lifting heavy tools and pumps. He testified that his job required him to lift up to one hundred (100) pounds, but that he does not lift alone.

Petitioner testified that on June 5, 2012, he was lifting a pump with a co-worker that weighed approximately one hundred and fifty (150) pounds, when he felt a terrible sharp, pain in his right shoulder and left wrist.

Petitioner testified that he continued to work because it was the end of day. He went home, continued to experience pain, so he took Ibuprofen. Petitioner testified that the Ibuprofen helped, so he went to work the next day. Petitioner testified that he attempted to work, but his right shoulder was too painful. He reported his injury to his supervisor Jesse Canet and was sent to Mercy Hospital.

Petitioner did not offer the certified records from Mercy Hospital, but testified that he reported right shoulder pain to the emergency room. Petitioner testified that he was prescribed Ibuprofen and other analgesics.

On June 7, 2012, Petitioner was evaluated by Dr. Homer Diadula, at MercyWorks. The medical records include the x-rays and diagnostic testing. During Petitioner's initial evaluation with Dr. Diadula, he reported lifting a water pump and injuring his right shoulder and left wrist. Petitioner reported right shoulder pain of 5/10, which was aggravated when he raised his right arm above shoulder level. Dr. Diadula noted that the petitioner's right shoulder showed no swelling, he had full forward flexion, negative supraspinatus isolation test, and internal rotation to the level of L1. Dr. Diadula also noted tenderness in the deltoid, acromioclavicular joint and bicipital groove and limited range of motion in all directions. Petitioner was diagnosed with a right shoulder sprain and taken off work. PX2.

On June 14, 2012, during a follow-up visit with Dr. Diadula, Petitioner complained of right shoulder pain 9/10 and a tingling sensation. Dr. Diadula ordered an MRI of the right shoulder.

On June 28, 2012, during his follow-up visit with Dr. Diadula, it was noted that Petitioner had not presented for the MRI, but was reporting right shoulder pain 10/10. Dr. Diadula recommended a right shoulder MRI for a second time.

On July 13, 2012, during his follow-up visit with Dr. Diadula, Petitioner again complained of right shoulder pain 10/10; but still had not received the MRI recommended on June 14, 2012.

On July 14, 2012, he underwent the MRI, which revealed a small, complete rotator cuff tear. On July 17, 2012, during a follow-up visit with Dr. Diadula, the MRI findings were discussed and Petitioner was referred to Dr. Heller, an orthopedic specialist at Midland Orthopedics.

On July 23, 2012, Petitioner was evaluated by Dr. William Heller, complaining of right shoulder pain, after lifting a water pump. Dr. Heller reviewed the MRI film and opined that the petitioner had a full thickness, rotator cuff tear and probable labral tear. Dr. Heller recommended arthroscopic cuff repair, and probable labral repair. Dr. Heller noted that because of Petitioner's age (65), he might require a biceps tenotomy.

On August 22, 2012, Dr. Heller performed right shoulder arthroscopic cuff repair, right shoulder long head biceps tendon resection, right shoulder arthroscopic subacromial decompression and right shoulder arthroscopy with extensive debridement. During the procedure, Dr. Heller noted significant capsulitis and synovitis.

On September 7, 2012, during his two-week status post-surgery, Petitioner reported that he was feeling well. Dr. Heller again noted Petitioner's age and referred him for physical therapy.

During Petitioner's two-month status post-surgery, he reported that he was not in any pain and that he continued to improve. Upon examination, it was noted that his shoulder had no swelling, erythema or ecchymosis. His active forward flexion was approximately 145 and abduction 140, but Dr. Heller was able to bring him to 160 of forward flexion and abduction. Dr. Heller referred Petitioner back to physical therapy.

On November 30, 2012, Dr. Heller noted that the petitioner was progressing nicely, but required more therapy.

On January 7, 2013, Dr. Heller noted that the petitioner had normal motion, minimal pain and residual weakness when lifting overhead. Upon examination, Petitioner's forward flexion and abduction was between 100 and 150 degrees with no crepitus or locking. Dr. Heller referred Petitioner for a two-week work-conditioning program.

On January 28, 2013, during a follow-up visit with Dr. Heller, it was noted that the therapist in work hardening felt that because of the petitioner's age and diabetes mellitus, he would be unable to return to his pre-injury job. Dr. Heller advised that Petitioner complete work conditioning and return to him for an evaluation to determine if he was at maximum medical improvement ("MMI").

On February 11, 2013, Dr. Heller placed the petitioner at MMI and released him to return to work with restrictions. The petitioner was given restrictions of fifteen (15) pounds lifting above shoulder level and thirty-three (33) pounds lifting below shoulder level. Petitioner could perform thirty-three (33) pound floor to knuckle level, eighteen (18) pounds knuckle to shoulder level, fifteen (15) pounds shoulder to overhead level and push/pull thirty (30) pounds for a 25-foot distance. Overall, Dr. Heller

felt that the petitioner was unable to perform heavy labor because of his age and underlying medical conditions.

Petitioner has placed into evidence, bills from Midland Orthopedics, in the amount of $8,965.11 for the period of July 23, 2012 through February 11, 2013. Respondent has offered an explanation of benefits paid to Midland Orthopedics, for the period of July 23, 2012 through February 11, 2013, on Petitioner's behalf.

Dr. Anthony Romero evaluated Petitioner on April 22, 2013 and July 3, 2013, at the request of his attorney. Dr. Romero noted that he was evaluating the petitioner for a second opinion and ordered an MRI that primarily revealed degenerative changes and stated that the primary reason that the petitioner was still having pain in his right shoulder was due to arthritis and that he believed the petitioner was capable of working in a light duty capacity. PX3 & 4; RX1.

Petitioner testified that currently, he continues to have symptoms in his right shoulder and that sometimes, it is hard to reach for coffee cups and his seat belt. He testified that he cannot sleep on his right side and sometimes takes Tylenol three times per week. Petitioner testified that he has not received any treatment for his right shoulder since his release from Dr. Romero, on July 7, 2013.

Petitioner testified that Respondent was unable to accommodate his restrictions and he did not return to work. Petitioner further testified that he received a letter from the City of Chicago, advising him to look for work. He testified that he does not remember if he looked for work from February 12, 2013 through December 6, 2013. Petitioner did not provide any job logs or other evidence reflecting a job search for the period of February 12, 2013 through December 6, 2013.

On December 6, 2013, Petitioner met with Natalie Maurin, a vocational counselor at MedVoc Rehabilitation. During their initial meeting, Petitioner reported that he graduated high school in the Philippines and has two years of college, but did not obtain a degree. Petitioner also reported that he has training in truck driving, heating and cooling and environmentally safe refrigerant service techniques. Petitioner advised that he does drive, has a CDL and regular license and stated that he was not interested in computer training. Petitioner reported that he had only looked for one job since his release from work, with permanent restrictions. The Arbitrator notes that the petitioner testified that college in the Philippines is comparable to high school in the United States. RX2.

Petitioner was advised of his responsibilities in attempting to look for work; and was given a packet of information highlighting the same. During this visit, the petitioner stated that he wanted to work in positions for plumbing, heating and cooling; and that he did not want to work in an office or learn how to use a computer.

The MedVoc counselor opined that the petitioner was a candidate for several jobs and a vocational rehabilitation plan was established.

On January 15, 2014, a labor market survey conducted by MedVoc Rehabilitation, identified twenty-five (25) prospective employers and fifteen (15) responded favorably, indicating that they would hire someone like the petitioner. "The average wage range was $11.31 per hour to $13.31 per hour" with the median wage of the labor market survey being $12.31 per hour. Rx2, pp. 2-10.

On December 26, 2013, Petitioner met with Ms. Lauren Egle from MedVoc, at the Budlong Chicago Public Library. She reported that the petitioner was very inquisitive and wanted to know why he could not just settle his case and not participate in job placement. He was told to refer these questions to his counsel. He stated that it would be financially better to retire and take 40% of his salary rather than work a job paying the minimum wage. Petitioner asked Ms. Egle what would happen if he did not do what MedVoc recommended. Petitioner requested to cancel the January 2, 2014 meeting and stated that he did not want to participate in job placement. During this meeting, Petitioner indicated that he hated computers and stated that he did not want any training on or to work with computers. RX2; pp. 18-24.

On January 2, 2014, MedVoc provided the petitioner with job leads. On January 9, 2014, Petitioner again met with Ms. Egle and she noted that he was unprepared and had not contacted the required employers for the week. Petitioner stated that his nephew applied for online jobs, on his behalf. Ms. Egle requested the online confirmations and recommended that the petitioner participate in either formal computer training or one-on-one training. According to Ms. Egle, Petitioner refused training.

Petitioner testified, at trial, that he was fully compliant with vocational rehabilitation as provided by MedVoc and that he followed the instructions provided.

According to his counselor at MedVoc, Petitioner was repeatedly non-compliant and continuously sabotaged his job search efforts. Specifically, petitioner refused to provide confirmations of online applications, refused to meet the required prospective contacts, refused to apply to jobs in certain neighborhoods or with certain pay rates; and intentionally interfered with potential offers of employment.

According to MedVoc, on a number of occasions, the petitioner either did not apply to certain jobs or provided incorrect information, so the MedVoc counselor could not follow-up with the prospective employers. RX2, pp. 25-36.

Petitioner refused to apply for any jobs on the south side of Chicago because of fear of being harmed. When asked during the hearing about this issue, the petitioner testified that he wanted to stay on the north side of Chicago. Petitioner told the personnel at MedVoc that he was willing to go as far north as Wisconsin before going to the south side of Chicago. Petitioner was asked if his original job within the City of Chicago, required him to travel across Chicago and he answered in the affirmative.

Petitioner repeatedly stated that he wanted to retire while working with MedVoc, but stated at trial that he did not make that statement. According to MedVoc, Petitioner told them that it would be an embarrassment to take a job making anything less than $12.00 per hour. RX2.

On August 18, 2014, MedVoc sent Petitioner a letter indicating that he was not fully cooperating with vocational rehabilitation services. Because of petitioner's non-compliance, they recommended placing vocational rehabilitation efforts on hold.

On September 24, 2014, Petitioner contacted Mr. Howard Orloff regarding a potential job interview. According to MedVoc, Petitioner sabotaged the phone conversation by indicating that he was on disability because he hurt his back, and that the reason he was looking for work was because "they"

told him to look for work. On September 26, 2014, the petitioner's benefits were terminated for non-compliance.

On October 10, 2014, MedVoc personnel and Tagala, a Filipino interpreter, met with Petitioner and his attorney, to go over Petitioner's responsibilities while working with MedVoc. Following the meeting, Petitioner stated that he understood what was required of him and that he would become compliant. Petitioner's benefits were reinstated. RX2.

According to Ms. Egle of MedVoc, following the meeting, Petitioner continued to be non-cooperative by failing to produce the required contacts, not performing his own job search; and intentionally sabotaging potential job opportunities. RX2; Reports of November 25, 2014, December 30, 2014, January 26, 2015, March 3, 2015.

According to MedVoc, the petitioner sabotaged potential employment with Hawk Ford and GrubHub. While at Hawk Ford for an application submission, Petitioner was given an on the spot interview with Norman, a manager. Petitioner indicated that he did not want to work nights because the neighborhood was bad. Petitioner walked away from Norman while, he was still talking. The petitioner's behavior was so odd that Norman asked the MedVoc counselor whether the petitioner understood English.

Norman asked the petitioner to perform a drug test at Little Company of Mary, which he did. The technician at Little Company of Mary advised that the blood test results would be available January 26, 2015. According to the MedVoc counselor, the petitioner did not want to follow-up with Norman as recommended by MedVoc. The counselor spoke to Norman and he told them that he had not heard from the petitioner.

Petitioner testified that he did not get the job at Hawk Ford because the job required him to shovel snow. According to his counselor at MedVoc, Petitioner never reported that information.

During their February 10, 2015 meeting, Petitioner applied online for a job at Panera Bread, with his counselor's help. While applying for this job, petitioner indicated that he could not stand on his feet for extended periods. When asked why he said that, petitioner indicated that he had restrictions from an injury many years ago. It should be noted that the petitioner was not given restrictions of no standing for the injury arising out of the June 5, 2012 accident.

According to MedVoc, the petitioner declined to interview for a job at GrubHub. Petitioner told his counselor that the driver's position at GrubHub had a base pay of $2.50 an hour and that the person he spoke to at GrubHub, told him that with tips, delivery drivers average $15.00 per hour. Petitioner then stated that he was not interested in driving from house to house.

According to MedVoc, Petitioner's job search efforts were less than diligent and Petitioner was less than cooperative with the program. Petitioner continuously allowed others to conduct his job search for him, failed to properly document his job search efforts, refused to apply for certain jobs and sabotaged potential job opportunities. Presently, Petitioner has not found a job.

Petitioner testified that at the time of the injury, his hourly wage was $35.00. He testified that he was a member of local union 1092 and that an unnamed co-worker told him that the hourly rate was currently $38.00. Petitioner further testified that he did not contact the union prior to his hearing and that he does not have anything in writing stating what his current rate of pay would be. Petitioner did not provide a copy of his union contract or any evidence from his department identifying his current rate of pay.

CONCLUSIONS OF LAW

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

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

On August 22, 2012, Dr. Heller performed right shoulder arthroscopic cuff repair, right shoulder long head biceps tendon resection, right shoulder arthroscopic subacromial decompression and right shoulder arthroscopy with extensive debridement. During the procedure, Dr. Heller noted significant capsulitis and synovitis.

Following his surgery, the petitioner participated in post-operative physical therapy and work conditioning. Petitioner reported and Dr. Heller agreed that his recovery went well. Upon examination, Dr. Heller noted that Petitioner's right arm was within normal recovery, there was no swelling, erythema or ecchymosis noted. Upon discharge from care, Dr. Heller noted that Petitioner was able to forward flexion and abduction between 100 and 150 degrees with no crepitus or locking.

On February 11, 2013, Dr. Heller placed the petitioner at MMI and released him to return to work with restrictions. The petitioner was given restrictions of fifteen (15) pounds lifting above shoulder level and thirty-three (33) pounds lifting below shoulder level. Petitioner could perform thirty-three (33) pound floor to knuckle level, eighteen (18) pounds knuckle to shoulder level, fifteen (15) pounds shoulder to overhead level and push/pull thirty (30) pounds for a 25-foot distance. Overall, Dr. Heller felt that the petitioner was unable to perform heavy labor because of his age and underlying medical conditions.

Dr. Heller and the work-conditioning therapist seemed to be under the false that the petitioner had to lift 160 pounds, by himself, on a daily basis. The petitioner testified that he had to be able to lift up to 100 pounds and when he did lifted that kind of weight, he did it was with a partner.

Dr. Romero evaluated Petitioner for a second opinion and when he ordered an MRI, it revealed primarily degenerative changes. Romero further noted that Petitioner's shoulder pain, appeared to be the result of arthritis; and that he believed petitioner was capable of working in a light duty capacity.

The Arbitrator concludes that the petitioner's current condition of ill-being regarding his shoulder, is directly related to his age and his pre-existing degenerative condition and is not related to the June 5, 2012 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?

Petitioner treated with Midland Orthopedics and Dr. William Heller from July 23, 2012 through February 11, 2013 and alleges that $8,965.11 remains outstanding. Petitioner has failed to establish which dates of service remain unpaid as Petitioner's Exhibit 3 provides balances, but also reflects credits for payments made by the respondent. The only date that reflects some potential issue is August 22, 2012.

Respondent offered Exhibit 1, as an explanation for benefits paid to Midland Orthopedics/Dr. William Heller, which include check numbers. Respondent's exhibit 1 provides the dates of payment and check numbers for bills paid.

On February 22, 2013, Respondent sent Midland Orthopedics check number 41718804, in the amount of $8,886.48, for bills accrued on August 22, 2012 with CPT codes; 29823, 29827, and 29826. Respondent alleges that CPT code 23440 is for a transplant/removal of a tendon and that this CPT code was not paid because it was not reasonable or necessary. The Arbitrator does not agree and concludes that this procedure is part of the necessary and reasonable operation; and should be paid for by the respondent.

On May 23, 2012, respondent sent Midland Orthopedics check number 10774859 in the amount of $581.88 for bills accrued on August 22, 2012 with CPT code 29823(80).

The Arbitrator finds that based on the evidence presented, Respondent has not paid all reasonable and necessary medical expenses if it has not paid for those bills stated in Petitioner's Exhibit 3.

K. What temporary benefits are in dispute?"

The Arbitrator finds that Petitioner failed to comply fully with vocational rehabilitation services and failed to provide a diligent job search. The Arbitrator finds that the petitioner's attitude intentionally sabotaged his job search efforts and interfered with his ability to secure adequate and gainful employment. As such, petitioner is not entitled to maintenance benefits.

Petitioner testified that he received a letter from the City of Chicago advising him to look for work. He testified that he does not remember if he looked for work from February 12, 2013 through December 6, 2013. Petitioner did not provide any job logs or any evidence reflecting a job search for the period of February 12, 2013 through December 6, 2013.

The evidence is supportive of the position that the petitioner did not want to participate in vocational rehabilitation or conduct a viable job search. The evidence and testimony also support the fact that the petitioner did not make the minimal contacts required and that he did not do his own job search. Petitioner testified and the MedVoc reports support that petitioner's nephew, son-in-law and wife did his on-line job searches. While this might have been acceptable, in that the petitioner testified that he was not computer literate, he did not utilize his family's on-line efforts, to further a valid job search.

Petitioner failed or refused to provide confirmations of his online application submissions, so the MedVoc counselor could confirm whether petitioner actually applied for the jobs he listed.

In addition, Petitioner provided incorrect contact information for jobs he listed, thereby making it impossible for MedVoc to confirm his application submissions. On numerous occasions, MedVoc personnel contacted the employers provided by the petitioner and found that petitioner never applied for the position or at most, applied incorrectly.

Petitioner refused to apply to positions that paid less than $15.00 per hour and refused to attend interviews or accepts jobs if they were on the south side of Chicago.

Petitioner argues that he lacked the requisite comprehension, understanding and education to be fully compliant with vocational rehabilitation however; he apparently sabotaged in-person interviews, phone interviews and the scheduling of job interviews. Even if the petitioner did not comprehend or understand his responsibilities and duties when initially working with the MedVoc counselor, his argument remains meritless because his responsibilities were explained to him by a Filipino interpreter; and after numerous attempts, on the counselor's part, to help Petitioner find a job, his non-compliance continued. The Arbitrator notes that the petitioner worked for the respondent for sixteen (16) years and did not require the use of an interpreter or have any reported difficulty with understanding his job duties and responsibilities.

The Commission has found that 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. 1991).*

The Supreme Court has held that, it is the petitioner's obligation to make "good-faith efforts to cooperate in the rehabilitation effort." *Archer Daniels Midland Co. v. Industrial Commission, 138 ILL.2D 107, 561 N.E.2D 623, 149 Ill.Dec.253 (1990).*

The Commission has also held that when the petitioner lacks the intent to return to work... the employee is (was) not entitled to benefits and was not permanently and totally disabled. *Schoon v. Industrial Commission, 259 Ill.App.3d 587, 630 N.E.2D 1341, 197 Ill. Dec 217 (3d Dist. 1994).* This petitioner has indicated, several times, that he would be better off if he just retired without having to submit to the vocational rehabilitation process.

As such, the Arbitrator concludes that the petitioner is not entitled to maintenance benefits, as he has not shown good faith effort or cooperation with the rehabilitative process. Respondent shall receive a credit for maintenance benefits paid for the period of February 12, 2013 through March 17, 2015.

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

The petitioner has failed to meet his burden to prove, by a preponderance of the evidence, that he is entitled to a wage differential, as provided in Section 8(d) 1 of the Act. The petitioner has failed to satisfy the second prong of 8(d)1, regarding the average amount which he is earning or is able to earn in some suitable employment or business after the accident.

Petitioner failed to make a good faith effort to cooperate with vocational rehabilitation services provided by the respondent, by either sabotaging his efforts or making no effort at all to seek employment from job leads provided to him. Petitioner has been unable to find a job within his restrictions.

Petitioner has introduced into evidence a labor market survey conducted by MedVoc Rehabilitation services, which indicates that the petitioner is employable and that there is a stable job market for him. The labor market survey indicates that the median wage is $12.31.

Petitioner testified that at the time of the injury his hourly wage was $35.00 per hour and was a member of local union 1092. He further testified that his co-worker told him that the current, hourly rate is $38.00. Petitioner testified that his co-worker was a construction laborer, and that there are different types of laborers. He also testified that different laborers are paid different amounts based on the time they have worked for the City and their job title. Petitioner was unable to say what his exact job title was; only that he was a laborer.

Petitioner testified that he did not contact the union prior to his hearing and that he does not have anything in writing stating what his current rate of pay would be as of the date of hearing. Petitioner did not provide a copy of his union contract or any evidence from his department identifying his current rate of pay and Petitioner's unnamed co-worker did not testify.

The Arbitrator finds that the petitioner's testimony regarding his personal knowledge that his current hourly wage would be $38.00, is not supported by valid evidence and therefore is not persuasive. The Arbitrator finds that the petitioner has failed to prove, by a preponderance of the evidence, that he is entitled to a wage differential, as provided in the Workers' Compensation Act. The Arbitrator awards 30% loss of use of a person.

16IWCC0426

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12WC37878
SIGNATURE PAGE

L Thompson Smith
Signature of Arbitrator

April 16, 2015
Date of Decision

APR 17 2015

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

Theresa A. Tuntland,

Petitioner,

vs.

NO: 14 WC 37698

Village of Hanover Park - Police Department,

16IWCC0427

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 June 29, 2015, is hereby affirmed and adopted.

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

16IWCC0427

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: JUN 2 3 2016
TJT:yl
o 6/21/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

TUNTLAND, THERESA A
Employee/Petitioner

Case# 14WC037698

VILLAGE OF HANOVER PARK-POLICE DEPT
Employer/Respondent

16IWCC0427

On 6/29/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1497 MORICI FIGLIOLI & ASSOC
DAVID FIGLIOLI ESQ
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

0075 POWER & CRONIN LTD
WILLIAM P DEWYER
900 COMMERCE DR SUITE 300
OAK BROOK, IL 60523

16IWCC0427

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)

Theresa A. Tuntland
Employee/Petitioner

v.

Village of Hanover Park-Police Department
Employer/Respondent

Case # 14 WC 37698

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **April 23, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **August 11, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**63,433.46**; the average weekly wage was $**1,219.87**.

On the date of accident, Petitioner was **27** 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, $ for a total credit of $**0**.

ORDER

The Respondent shall pay the Petitioner temporary total disability benefits of $813.25 per week for 5/7 weeks, from November 1, 2014 through November 5, 2014, as provided in Section 8(b) of the Act, because the injury sustained caused the disabling condition of the Petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

The Respondent shall pay the unpaid medical bills, which were for reasonable and necessary medical services of St. Alexis Medical Center, Hand Surgery Associates and Center for Sports Ortho pursuant to the Medical Fee schedule or by prior agreement, whichever is less as provided in Section 8(a) and 8.2 of the Act.

The Respondent shall authorize and be responsible for the payment of the surgical procedure to Petitioner's left wrist as recommended by Dr. Sam Biafora in order to attempt to repair the TFCC injury and/or, to repair and correct the distal ulnar instability which has been found in Petitioner's left wrist.

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

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

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

Deborah L. Simpson
Signature of Arbitrator

June 19, 2015
Date

ICArbDec19(b)

JUN 29 2015

16IWCC0427

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Theresa A. Tuntland,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 37698**
	)	
Village of Hanover Park Police Department,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on August 11, 2014, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $63,433.46, and that her average weekly wage was $1,219.87.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries or was she last exposed to an occupational disease that arose out of and in the course of employment; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Is the Respondent liable for the unpaid medical bills for St. Alexis Medical Center, Hand Surgery Associates and Center for Sports Ortho; (4) Is Petitioner entitled to TTD from November 1, 2014 through November 5, 2014; and (5) Is the Petitioner entitled to prospective medical care.

STATEMENT OF FACTS

On August 11, 2014, the Petitioner was employed as a police officer for the Respondent. She had been employed by the Respondent in this capacity for approximately 2-1/2 years. The Petitioner testified that, as a police officer, she was assigned to regular patrol duties, dressed in the standard police uniform and drove a marked squad car. Her job duties were to respond to all emergency calls for service, to enforce all traffic, municipal and state laws, to control, apprehend and detain people, to make arrests when necessary, to search people and vehicles, move motor vehicles out of traffic if they create a hazard and to assist ambulance crews when necessary.

When she was initially hired by the Respondent, she had to complete a police training course at the police academy at the College of DuPage, involving basic police work and

responsibilities. At times the class was very physical in nature. Petitioner also had to pass a "Power Test" which required various types of lifts with weights and other exercises. She successfully completed this course of training and passed the required "Power Test."

The Petitioner testified that up to August 11, 2014, she was able to perform all the job duties required of a police officer without difficulty and that she had never suffered any type of injury or received medical treatment to her left hand or left wrist.

The Petitioner next testified that on August 11, 2014 she was assigned to work patrol on the night shift which began at 6:00 p.m. and ended at 6:00 a.m. the following morning. At approximately 9:30 p.m. she received a dispatch call to respond to a disturbance at the Hollywood Bliss, a local restaurant, no other details were provided. When she arrived at that restaurant, she met with the owner who advised her that a female subject had entered the restaurant and jumped on a table and began dancing and acting erratically. When he advised her that he would call the police, the woman left the premises. The Petitioner then searched the immediate area for this woman but was unable to locate her. She went back to the restaurant and viewed a videotape of the incident to identify the female subject and asked the owner if he wanted to sign a complaint, to which he declined.

A short time later, the Petitioner received another dispatch call of a disturbance at a Burger King restaurant a half a mile away. When she arrived at that location, she observed a person who appeared to be the same female subject who had created the disturbance at the first restaurant. According to the Petitioner, when this female subject saw her drive up in the squad car, she ran away from the restaurant across Irving Park Road. The Petitioner identified herself as a police officer and told the woman to stop. The Petitioner then ran after her, crossing the street as well and chased her as she ran behind a building.

The Petitioner testified that when she ran behind the building it was dark and she tripped over something and fell onto a grassy surface landing on her hands with her arms extended forward. She was about four to six feet away from the woman. She picked herself up and began chasing the female subject again and when she caught up to that running subject, she placed her hands on the subjects upper and lower back and pushed her down. The Petitioner further related that she fell on top of this female subject as she pushed her to the ground. Petitioner stated that she landed on top of the woman, with her hands in a flexed position. She then held her to the ground and when she was able to control her, she placed her in handcuffs.

Shortly thereafter, her supervisor, Sergeant McClaughry arrived at the scene and assisted her in the investigation and ultimate arrest of this person.

The Petitioner next testified that this female subject was continuing to act erratically after she was placed in handcuffs and it was determined that she should be transported to the hospital for a psychological evaluation. When the paramedics were called to the scene to transport her and the handcuffs were taken off her, she flailed her arms and struck one of the paramedics. The Petitioner then assisted the paramedics in restraining the subject again in the back of the ambulance and it was determined that she should be arrested for disorderly conduct and battery on the paramedic that she struck.

The Petitioner then testified that after this incident, she noticed that she had bumps, bruises and scrapes on her knees and on the palms of her hands and general soreness in her wrists and forearms but she did not feel that these were significant enough to report them to her supervisor. The Petitioner stated that she had experienced minor injuries in the past while working as a police officer for the Respondent and never felt it was required to formally report these minor injuries to her immediate supervisor or the department. She also testified that she did not record these minor injuries or the fact that she had fallen twice during this incident in the department arrest report because she felt it was not significant or relevant. (RX #9)

According to the Petitioner when she worked her next duty shift, which began on August 12th at 6:00 p.m. and ended on August 13th at 6:00 a.m., she continued to experience general soreness in her hands, wrists and forearms but because it was a quiet shift, she did not have to perform any strenuous work activities. She was then off work for the next two days and began to notice a little stiffness in her left wrist and forearm in addition to the general soreness she experienced since the incident occurred.

When she reported back to work on Friday, August 15th at 6:00 p.m. and began to perform her regular patrol duties, she began to notice an increase in the stiffness and soreness in her left wrist and forearm.

On the following day which was Saturday, August 16th she also worked her regular patrol shift that began at 6:00 p.m. and related that this was a very busy shift with multiple calls for service. Early on Sunday morning, she received a dispatch call for a burglary to auto in progress and she responded to that location using her emergency lights and siren. While driving to that call, she had to turn the steering wheel quickly and forcefully and when doing that maneuver, she felt a sharp pain in her left wrist that radiated into both her forearm and fingers. When this pain did not subside, she reported this to her supervisor; Sergeant McClaughry. The Petitioner was then required to complete various incident and injury reports (RX #4 & #5) and her supervisor completed additional reports. (RX #6 & #7)

The Petitioner was then ordered by Sergeant McClaughry to go to St. Alexis Medical Center emergency room for treatment. At that facility it was recorded that the Petitioner provided a history of suffering an injury to her left wrist when she tackled a person while at work. It was also recorded that she had "an achy pain" since Monday which was worse with movement and better with rest. With respect to treatment, her left wrist was x-rayed; she was given a splint to use and was referred for follow up care to the occupational health clinic. The diagnosis from the emergency room physician was that she had sustained a left wrist sprain and she was advised to work only light duty. (PX #1)

The Petitioner then received medical treatment at the Alexian Brothers Occupational Health Clinic. She was initially evaluated at this facility on August 18, 2014. The history recorded at this initial visit was that Petitioner had sustained an injury to her left wrist while "trying to restrain an individual" and the injury date was recorded as August 11, 2014. Based upon an examination of the Petitioner, a diagnosis of left wrist sprain/strain was made with the possibility of a triangular fibrocartilage tear (TFCC). An MRI was recommended and a

limitation of no driving a company vehicle and to avoid altercations was imposed by the physician. (PX #2)

The Petitioner underwent an MRI to her left wrist on August 26, 2014 and was re-evaluated by the physician at the occupational clinic on August 28, 2014. The MRI was reviewed which did not show "convincing evidence of a TFCC tear" and it was recommended that the Petitioner begin a course of physical therapy. This was also done at the occupational clinic. The Petitioner testified however that the therapy caused her to experience increasing pain in her left wrist with certain movements. She was then referred to a hand specialist for further evaluation. (PX #2)

On September 24, 2014, the Petitioner was evaluated by Dr. Sam Biafora an orthopedic hand specialist who was affiliated with the occupational clinic. The history provided to Dr. Biafora by the Petitioner was that "She was struggling with an assailant on August 11, 2014 when she fell and landed onto her left wrist." The doctor examined Petitioner's left wrist, reviewed both the x-rays and the MRI and rendered a diagnosis that she had sustained a "likely TFCC sprain versus tear." He then performed an injection to her left wrist and prescribed medication and a splint. She was released to perform sedentary work only and to follow up in three weeks. (PX #2 & #3)

The Petitioner testified that the injection performed by Dr. Biafora resulted in short term relief only and her left wrist pain returned. She then followed up with Dr. Biafora on October 15, 2014 and he continued to prescribe the use of a splint and to remain under a sedentary work restriction. The Petitioner next saw Dr. Biafora on November 5, 2014 and since her condition did not improve, he recommended a left wrist arthroscopy in order to repair a possible left TFCC tear. Dr. Biafora further opined; "The patient is a police officer that sustained an injury when she fell during an altercation. I believe that her current condition is related to that event." (PX #3; chart note of 11/5/14) The Petitioner then discussed with Dr. Biafora a return to full duty work pending approval of the recommended surgery and the doctor released her without restrictions at that time. The Petitioner continued under the care of Dr. Biafora and saw him again on December 3, 2014, January 14, 2015 and February 25, 2015. During this time period, Dr. Biafora continued to recommend the arthroscopic surgical procedure to Petitioner's left wrist and allowed her to work full duty as a police officer. (PX #2 & #3)

The Petitioner also sought a second opinion from another orthopedic specialist; Dr. Keith Komnick. She was evaluated by Dr. Komnick on October 27, 2014. At that evaluation, the Petitioner provided a history of "a left wrist injury that occurred a couple of months ago when she was chasing a subject and fell on an outstretched wrist. Several days later she noticed that rotating or turning the forearm caused significant pain in the wrist at the ulnar aspect." Dr. Komnick performed an evaluation of Petitioner's left wrist, reviewed x-rays and offered a diagnosis of left distal ulnar wrist pain. He agreed with the treatment plan offered by Dr. Biafora in that if conservative measures fail, surgery would be appropriate. (PX #5)

At the request of the Respondent, the Petitioner was evaluated by Dr. Bryan Neal on October 16, 2014, pursuant to Section 12 of the Act. In his report of this evaluation, Dr. Neal reported that the Petitioner provided a history that "on August 11, 2014, she had responded to a

call. She arrived on the scene and a female took off running. She pursued her and during this stated, I tripped and fell. She got up and continued running after the subject....In time she caught up with the person she was chasing. She pushed her to the ground with both of her hands. She then fell on top of her...When she fell on top of the other individual both of her hands landed on the person. She eventually arrested this individual." Upon physical examination of the Petitioner, Dr. Neal noted diminished supination of the left wrist, the left distal ulna was more prominent when compared to the right side and instability was noted to the left distal ulna with movement. The Petitioner experienced pain when manipulating the distal ulna and had significant pain with ulnar grind testing. Dr. Neal also reviewed the MRI studies and stated that he observed fluid signal intensity about the TFCC and distal ulna region on several of the images. Based upon these findings, his diagnosis was that the Petitioner was suffering from left ulnar-sided wrist pain secondary to dorsal distal ulna instability. (RX #1; Deposition Exhibit #2)

Dr. Neal then offered several opinions based upon his evaluation of the Petitioner and his review of various records and reports. He first opined that "the cause of Petitioner's left wrist condition is usually a wrist injury where there is soft tissue disruption to the dorsal capsular stabilizers. This can be the TFCC tissue, the dorsal capsular tissue and even to some extent the extensor carpi ulnaris." He next opines that "This type of condition is one that can result from a fall onto an extended wrist or forceful rotation of the forearm, especially against resistance. Both might have occurred according to the examinee's history on August 11, 2014. One does not expect this type of condition to develop from the process or positioning while riding a motorcycle." He then opines "assuming that she had an actual left wrist injury at work on August 11, 2014, which produced temporally appropriate pain (within a few days), then I would assign causation." However, he further states that based upon his review of all of the medical records and other reports and documents provided to him, "it is my opinion I cannot conclude, find or support there is a causal relationship between a work event of August 11, 2014 and her left wrist condition." (RX #1; Deposition Exhibit #2)

Lastly, Dr. Neal opined that given his review of the MRI studies and his clinical examination of the Petitioner, he suspects that she does have TFCC and/or dorsal capsular soft tissue pathology and she would be a reasonable surgical candidate at the time of that evaluation. (RX #1; Deposition Exhibit #2)

Dr. Neal then authored an addendum report dated March 6, 2015 after reviewing a narrative report completed by Dr. Biafora. In this addendum report, Dr. Neal changed his opinion with respect to whether the Petitioner should undergo a surgical procedure to her left wrist. It was now his opinion that any surgical procedure, if done, should also address the dorsal distal instability that he feels she is experiencing in her left wrist. Additionally, the need for this surgery was a purely subjective determination to be made by the Petitioner based upon the degree of her continued symptoms. (RX #1; Deposition Exhibit #3)

The Petitioner testified that after she had been released for full duty work by Dr. Biafora and had been working for several weeks, she was ordered by the Chief of the Police Department to undergo a "Fitness for Duty Examination." This order from Chief David Webb, was provided to her in a written administrative memorandum dated December 18, 2014. (PX #6) She then reported to the occupational clinic and was re-evaluated by a physician Glenn Garofalo. This

physician after concluding his examination of the Petitioner, agreed with Dr. Biafora's recommendation that she could continue to work full duty without restrictions pending her surgery for a TFCC tear. He also completed a Duty Status Report with the notation; "officer may experience left wrist pain with certain activities due to work related injury." (PX#2)

With respect to her current condition, the Petitioner testified that she continues to experience a sharp pain in her left wrist with certain movements and a dull pain that is manageable when wearing her splint. She also experiences a constant stiffness in her left wrist. To control these continued symptoms she uses ice frequently and over the counter medication. She also stated that she wishes to undergo the surgical procedure as recommended by Dr. Biafora but could not do so because she would miss time from work afterwards and did not have enough accrued sick days to be paid for the time off work. Lastly, she testified that she had not suffered any additional injuries to her left wrist after August 11, 2014.

On cross examination, the Petitioner related that after arresting the woman and transporting her to the hospital for a psychological evaluation, she noticed that her uniform pants had dirt on the areas around her knees, there was mud on the bottom of her boots but her pants were not ripped or torn. She also noticed that her hands and knees were scrapped and her knees were bleeding slightly. She acknowledged that she did not say anything to the hospital personnel about these minor injuries but was provided with a wet paper towel by a nurse to wipe off her scrapes. She also confirmed that she did not record in any of the department reports that she completed that she had fallen during this incident nor did she report that she had suffered scrapes to her hands and knees during this incident. She further stated that the stiffness in her left wrist began on August 12, 2014.

Sergeant Kathy McClaughry was called as a witness by the Respondent. She testified that she was the shift patrol sergeant on the date of the incident; August 11, 2014. She confirmed that the Petitioner had responded to a dispatched call of a woman causing a disturbance in a restaurant and that this woman was acting irrationally. She also confirmed that she arrived at the location where the Petitioner had caught up to the woman who was acting irrationally and assisted the Petitioner in handcuffing the woman, then she assisted other officers and paramedics who arrived at the scene to ultimately secure her for transportation to the hospital and eventually the police department. According to Sgt. McClaughry, the Petitioner was required to follow the paramedics and ambulance to the hospital because the woman was placed under arrest and was in handcuffs and when she was released from the hospital, the Petitioner would have to take her back to the police station for processing. Sgt. McClaughry also testified that she did not see the Petitioner run after this subject or see her fall onto the subject when she arrived at the scene. Sgt McClaughry confirmed that the Petitioner was breathing hard as if she had been running and/or struggling with this woman just prior to the Sergeant's arrival on the scene.

Sgt. McClaughry testified that she did not notice any tears or dirt on Petitioner's uniform but also admitted that it was dark at the location of this incident which would make it difficult to see these conditions on a dark colored uniform. She also stated that the Petitioner did not report that she had suffered any injuries as a result of this incident on the day that it happened. It was not until August 17, 2014 that the Petitioner first reported an injury to her and that the Petitioner felt it occurred as a result of the August 11, 2014 incident. Sgt. McClaughry also identified

various reports she completed as a result of the Petitioner reporting her left wrist injury to her. These reports do not document that the Petitioner related she had fallen but that she may have suffered her left wrist injury when she was apprehending a subject and pushed her to the ground on August 11, 2014. (RX # 6, #7, #8 & #10)

Sgt. McClaughry testified that it is department policy that all police officers are required to immediately report any injury they suffer no matter the severity of the injury and they must fill out various incident and injury reports recording how the injury occurred. If they fail to do so, they can be disciplined.

Sgt. McClaughry also authenticated the recording of the arrest of the subject which occurred on August 11, 2014. This was taken by the video camera mounted on her squad car. This video also recorded the radio conversations of the officers who were on the scene of this incident. The video confirms that this subject was acting irrationally and had to be controlled by being placed in handcuffs. It also shows the Petitioner standing beside her and the audio portion reveals that the Petitioner was breathing at a rapid rate as if she had been running. (RX #2)

Doctor Sam Biafora; Petitioner's treating physician testified by evidence deposition. Dr. Biafora testified that on the initial appointment with the Petitioner she related a history of "struggling with an assailant in some type of altercation on August 11, 2014, when she fell, landing onto her wrist, left wrist. She then noted progressively increasing ulnar sided left wrist pain." (PX #4; p.14) After conducting his examination and reviewing various diagnostic tests, he formulated a diagnosis that she suffered a TFCC sprain or possible tear. He then opined that this left wrist injury was caused by the work accident as she described it which occurred on August 11, 2014. Specifically, the mechanism of a fall on an outstretched arm can cause an injury to the TFCC of the wrist. (PX #4; p.17-18, 25-26) Dr. Biafora further opined that it was a reasonable presentation that the Petitioner may not have noticed left wrist pain for a day or two after the initial incident if she had other bumps and bruises from the altercation or fall and she was not using her hands and wrists forcefully over the following few days. (PX #4; p.28-31, 34-35, 49) Dr. Biafora also opined that if it were determined that the Petitioner did not fall during this incident, it would not change his opinion with respect to medical causation because if the Petitioner had to forcefully push a person to the ground, that action is the same biomechanically as falling onto an outstretched hand and would cause a TFCC injury. (PX #4; p.57-58)

Doctor Bryan Neal, the Section 12 Examiner, also testified by evidence deposition. Dr. Neal testified that the history the Petitioner provided to him at his evaluation was that she was chasing a female subject on August 11, 2014 and fell while chasing her. She then regained her footing and caught up to this subject and pushed her to the ground with both of her hands and then fell on top of her. (RX #1; p.16-17) After performing a physical examination of the Petitioner and reviewing medical records and diagnostic reports and films, he offered his diagnosis that the Petitioner was suffering from left dorsal distal ulnar instability. He also opined that she may have a tear of the TFCC because her complaints and clinical presentation are consistent with a TFCC injury and ulnar instability. (RX #1; p.20, 54-55) He next opined that in order to repair a TFCC injury you would need to perform a surgery either arthroscopically or in an open fashion and the need for surgery would be based upon the degree of Petitioner's on-going symptoms and her ability to perform activities. (RX #1; p.56, 77)

Dr. Neal further testified that both a TFCC tear and ulnar instability can be caused by a fall on an outstretched hand or a forceful pushing of the hand on an object which is similar mechanically to a fall. (RX #1; p.57-58, 72-73) Dr. Neal opined that the events that occurred on August 11, 2014 did not cause the Petitioner's left distal ulna dorsal instability because she did not include or note that she injured her left wrist in the police reports she completed. (RX #1; p.24) Dr. Neal admitted that he had no knowledge or training as to how police officers complete incident reports. (RX #1; p.49-53) Dr. Neal also agreed that he was provided with no information that the Petitioner had injured her left wrist in any other manner except in the incident of August 11, 2014 and that she had reported no prior injuries or subsequent injuries to her left wrist. He also stated that he did not know what caused Petitioner's injury to her left wrist. (RX1; p.58-59, 70)

Ofc. Joseph Stranski testified that he is a police officer employed by the Respondent as well. He testified that he knows and recognizes the Petitioner as she was a fellow police officer. He testified that on August 17, 2014 he was at a Mobile Gas Station at approximately 10:10 p.m. working an overtime detail when he noticed the Petitioner driving a motorcycle, a sports type cycle or racing bike, not a Harley. He testified that the Petitioner pulled into the Mobile station and put gas in the tank. He said that they made small talk and he noticed that she had a brace on her left wrist. He was aware that she had been injured but did not have any details regarding her medical restrictions.

The Petitioner testified that she does own a Kawasaki Ninja, it is a sport bike. She testified that on August 24, 2014 she did ride the bike to the Mobile gas station to fill the tank so that she could put the bike away for the winter. That was the only time she rode the bike during the period she was injured. She did not have any restrictions regarding driving her personal vehicles. She does not remember seeing anyone she knew or talking to anyone.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,*58 Ill. 2d 226, 317 N.E.2d 515 (1974

To be compensable under the Act, the injury complained of must be one "arising out of and in the course of the employment". *820 ILCS 305/2*(West 1998). An injury "arises out of"

one's employment if it originates from a risk connected with, or incidental to, the employment, involving a causal connection between the employment and the accidental injury. *Parro v. Industrial Comm'n,* (1995) 167 Ill. 2d 385,393, 212 Ill. Dec. 537, 657 N.E. 2d 882.

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by a preponderance of the credible evidence that the Petitioner sustained accidental injuries to her left wrist that arose out of and in the course of her employment with the Respondent and that her current condition of ill-being is causally related to the injury, as set forth more fully below.

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the Petitioner sustained an accidental injury, on August 11, 2014, that arose out of and in the course of her employment for the Respondent. This conclusion is based upon the testimony of the Petitioner which the Arbitrator finds credible. The Petitioner's testimony is consistent with the histories documented in the medical records completed by the various medical providers who treated and evaluated her for this injury and with the various police department reports and other evidence presented confirming the nature of the incident the Petitioner was involved in on August 11, 2014.

The Petitioner's uncontroverted testimony was that on August 11, 2014, she was assigned to respond to and investigate a disturbance at a restaurant caused by a female subject acting erratically. During this investigation she was able to identify and locate this female subject and ultimately chased her behind a building and pushed her down in order to control her and subsequently place her under arrest. When the Petitioner followed the suspect around the back of the building it was dark and she slipped and fell to the ground. She immediately got up and continued the chase. Petitioner caught up to the subject, then pushed the subject down to the ground and fell on top of her with her hands in a flexed position. It was during these falls that Petitioner hurt her wrist and hand. She did not believe the injury was serious and she continued working, not reporting the falls or the injury to her supervisor who arrived on the scene after she had the subject subdued.

The multiple incident reports completed by the Petitioner and her supervisors document that this incident occurred on the date and time the Petitioner testified to and that the Petitioner had to push the female subject to the ground in order to control her so she would not harm herself or continue to cause a disturbance. (RX #3 thru #10) The testimony of Petitioner's immediate supervisor, Sergeant Kathy McClaughry confirms that this incident happened and that the female subject was acting erratically and ultimately was arrested for striking a paramedic who was trying to assist them. Additionally, the recording of the arrest of the subject taken by the video camera mounted on Sgt. McClaughry's patrol vehicle clearly confirms that the female subject was acting erratically and the Petitioner was standing beside her while they were investigating who she was and what to do with her. Also, the audio portion of this recording clearly establishes that the Petitioner was breathing at a rapid rate as if she was out of breath from running and/or struggling with this subject. (RX #2)

The medical records presented in this case all contain the same history provided by the Petitioner that she felt her left wrist condition occurred as a result of her involvement in the incident that happened on August 11, 2014. This history was provided to the Respondent's evaluating physician; Dr. Bryan Neal who interviewed and examined the Petitioner pursuant to a Section 12 examination on October 16, 2014. Dr. Neal further opined that he found the Petitioner to "be reasonable and there was no tendency for symptom magnification or exaggeration." (RX #1; p.67-68)

The only evidence presented by the Respondent to attempt to refute that Petitioner had sustained an accident that arose out of and in the course of her employment on August 11, 2014, was that the Petitioner failed to report that she injured her left wrist until August 17, 2014, at which time she completed various injury reports and department memorandums. These initial injury reports and memorandums do not state that the Petitioner fell to the ground while chasing this female subject or that the Petitioner fell on top of the female subject when she pushed her to the ground. Also, the Petitioner failed to include in the formal police reports of the incident and the arrest of the female subject, that the Petitioner fell while chasing the suspect or that she fell on top of the suspect when she pushed her to the ground. The Petitioner was disciplined by the Department for failing to report the accident to her supervisors as soon as it occurred pursuant to Department policy. The Arbitrator finds that this evidence is insufficient to support a finding that the Petitioner did not suffer an accident on August 11, 2014 when weighed against the evidence confirming that this incident occurred in the manner described by the Petitioner.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the Petitioner's present condition of ill-being with respect to her left wrist is causally related to the work accident she sustained on August 11, 2014. This finding is based upon the testimony of the Petitioner which the Arbitrator finds credible and consistent with the medical records presented in this case. It is also supported by the opinions offered by the Petitioner's treating hand specialist; Dr. Sam Biafora and the treating occupational clinic physician; Dr. Glenn Garofalo. The Arbitrator further finds that the opinions offered by the Respondent's evaluating physician; Dr. Bryan Neal are not persuasive with respect to medical causation and are based upon speculation and conjecture.

The Petitioner testified that prior to August 11, 2014 she had never suffered an injury to her left wrist nor did she have any difficulty performing the job duties required of a police officer prior to that date. When the Petitioner was hired by the Respondent, she had to complete and pass an extensive police training course at the police academy at College of Du Page that was at times, very physical in nature. Petitioner also passed a required Power Test which included various types of lifts with weights and other exercises. This testimony was unrebutted.

The Respondent called the Petitioner's immediate patrol supervisor; Sergeant Kathy McClaughry as a witness and this supervisor offered no testimony or evidence that the Petitioner

had reported any prior injury to her left wrist or that she had difficulty performing police duties prior to August 11, 2014.

The Petitioner testified in great detail regarding what occurred on August 11, 2014 when she attempted to apprehend and control a female subject who was acting erratically and causing a disturbance at restaurants within the municipality. This incident was described in the various police department reports completed by the Petitioner and her supervisor albeit, these reports did not state that the Petitioner had initially fallen while chasing this subject or that she had fallen on top of this subject when she pushed her to the ground after catching up to her. All of these report did however, record that the Petitioner pushed this subject to the ground and that she had to be physically restrained and handcuffed. Given the nature and purpose of police incident reports it is not unusual that a police officer would not include every detail of what happened at the time, or that the police officer fell during the chase unless it was important to the incident itself.

The Petitioner testified that after this incident, she noticed that she had bumps, bruises and scrapes on her knees and palms of her hands and general soreness in her wrists and forearms but she did not feel that these were significant enough to report them to her supervisor. The Petitioner stated that she had experienced minor injuries in the past while working as a police officer for the Respondent and never felt it was required to formally report these minor injuries to her immediate supervisor or the department. She also testified that she did not record these minor injuries or the fact that she had fallen twice during this incident in the department arrest report because she felt it was not significant or relevant. The Arbitrator finds Petitioner's testimony with respect to her initial symptoms to be credible, even though Sgt. McClaughry testified that she and her fellow police officers in this department report all injuries they sustain, even very minor injuries such as scrapes, bumps or bruises.

With respect to medical causation, the Arbitrator finds the opinions offered by Dr. Sam Biafora, Petitioner's treating orthopedic hand specialist, to be the more persuasive opinions. Dr. Biafora testified that on the initial appointment with the Petitioner she related a history of "struggling with an assailant in some type of altercation on August 11, 2014, when she fell, landing onto her left wrist. She then noted progressively increasing ulnar sided left wrist pain." (PX #4; p.14) After conducting his examination and reviewing various diagnostic tests, he formulated a diagnosis that she suffered a TFCC sprain or possible tear. He then opined that this left wrist injury was caused by the work accident as she described it which occurred on August 11, 2014. Specifically, the mechanism of a fall on an outstretched arm can cause an injury to the TFCC of the wrist. (PX #4; p.17-18, 25-26) Dr. Biafora further opined that it was a reasonable presentation that the Petitioner may not have noticed left wrist pain for a day or two after the initial incident if she had other bumps and bruises from the altercation or fall and she was not using her hands and wrists forcefully over the following few days. (PX #4; p.28-31, 34-35, 49) Lastly, he opined that if it were determined that the Petitioner did not fall during this incident, it would not change his opinion with respect to medical causation because if the Petitioner had to forcefully push a person to the ground, that action is the same biomechanically as falling onto an outstretched hand and could cause a TFCC injury. (PX #4; p.57-58)

The Arbitrator also notes that Dr. Biafora is a physician that was not specifically chosen by the Petitioner. Rather, he is affiliated with the occupational clinic the Petitioner was referred

to by the emergency room physician where she was ordered to go for treatment by her supervisor on August 17, 2014. (PX #1 & #2) This is also the same occupational clinic where the Petitioner was ordered to undergo a "Fitness for Duty Evaluation" by the Chief of the police department on December 18, 2014. (PX #2)

The Arbitrator further finds that Dr. Biafora's medical causation opinion is supported by the opinion offered by Dr. Glenn Garofalo, the physician who evaluated the Petitioner during the "Fitness for Duty Evaluation" ordered by the police chief. This physician after concluding his examination of the Petitioner on December 18, 2014, agreed with Dr. Biafora's recommendation that the Petitioner could continue to work full duty without restrictions pending her surgery for a TFCC tear. He also completed a Duty Status Report with the notation; "officer may experience left wrist pain with certain activities due to work related injury." (PX #2)

The Arbitrator finds that the opinions offered by Dr. Bryan Neal, Respondent's evaluating physician are not persuasive and are based upon conjecture and speculation rather than the actual evidence presented in this case. Dr. Neal offered several opinions based upon his evaluation of the Petitioner and his review of various records and reports. He first opined that "the cause of Petitioner's left wrist condition is usually a wrist injury where there is soft tissue disruption to the dorsal capsular stabilizers. This can be the TFCC tissue, the dorsal capsular tissue and even to some extent the extensor carpi ulnaris." He next opined that "This type of condition is one that can result from a fall onto an extended wrist or forceful rotation of the forearm, especially against resistance. Both might have occurred according to the examinee's history on August 11, 2014." He then opines "assuming that she had an actual left wrist injury at work on 8/11/14 which produced temporally appropriate pain (within a few days), then I would assign causation." He further stated that based upon his review of all of the medical records and other reports and documents provided to him, "it is my opinion I cannot conclude, find or support there is a causal relationship between a work event of August 11, 2014 and her left wrist condition." (RX #1; dep. ex. #2). The basis of his opinion was that the Petitioner did not include or note that she injured her left wrist in the police reports she completed. (RX #1; p.24) This was his conclusion even though he admitted that he had no knowledge or training as to how police officers complete incident reports or what would be relevant and appropriate information that should be included in these incident reports. (RX #1; p.49-53)

Dr. Neal admitted that he received no information from any source that the Petitioner had injured her left wrist in any other manner or incident except in the incident of August 11, 2014 and that she had not reported any prior left wrist injury or any subsequent injury to that wrist. He also admitted that he did not know what caused Petitioner's left wrist injury. (RX #1; 58-59, 70)

The police reports and injury reports that Dr. Neal relies upon to opine there is no causal relationship between the incident of August 11, 2014 and Petitioner's left wrist injury all contain reference to the Petitioner having to push this female subject to the ground with her hands extended onto her back while she was chasing her. Dr. Neal then concedes that a wrist injury such as Petitioner's injury could be caused by the forceful pushing of a hand on an object which is similar mechanically to a fall onto an outstretched hand. (RX #1; p.57-58, 72-73) Based upon this, the Arbitrator finds that Dr. Neal's position is inconsistent and cannot be reconciled with the evidence presented in this case.

Given the above, the Arbitrator finds Dr. Neal's opinions with respect to medical causation to be less credible and less persuasive than those of Dr. Biafora and Dr. Garofalo and therefore adopts the opinions of Dr. Biafora and Dr. Garofalo that have been provided on this issue.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

Based upon the foregoing discussion, The Arbitrator finds that the treatment received by Petitioner was reasonable and necessary, and related to her work injury of August 11, 2014, as it pertains to her left wrist. The medical bills submitted as Petitioner's Exhibit #8 constitute reasonable and necessary medical treatment pursuant to Section 8(a) of the Act.

With respect to the bill from St. Alexis Medical Center, this bill was incurred as a result of treatment the Petitioner received in this facility's emergency room on August 17, 2014. This was the facility that the Respondent sent Petitioner to when she first reported her injury to her left wrist to her supervisor; Sgt. Kathy MClaughry. Petitioner's left wrist was x-rayed, she was given a splint to use and was referred for follow-up care to the Occupational Health Clinic on that date. (PX #1)

With respect to the medical bill from Hand Surgery Associates, this was a bill incurred as a result of Petitioner's treatment with Dr. Sam Biafora. Dr. Biafora is the orthopedic hand specialist the Petitioner was referred to from Respondent's chosen clinic Alexian Brothers Occupational Health for further treatment with respect to her left wrist injury. There has been no evidence presented by the Respondent that the treatment by Dr. Biafora was not reasonable or necessary medical treatment in order to provide relief from the results of Petitioner's work injury to her left wrist.

With respect to the bill from the Center for Sports Orthopedics, this is a bill for the evaluation performed on the Petitioner by Dr. Keith Komnick on October 27, 2014. The Petitioner testified that she sought a second opinion from Dr. Komnick in order to determine the appropriateness of the surgical procedure that was recommended by Dr. Biafora. Based upon Petitioner's testimony and the evidence submitted at arbitration, this was Petitioner's choice of a treating physician and the Petitioner was entitled to this choice as provided for under the Act. The Respondent offered no evidence showing that this second opinion was unreasonable or unnecessary.

The Arbitrator therefore awards the following in medical expenses; $1,368.00 for the services provided by St. Alexis Medical Center, $464.00 for services provided by Dr. Biafora and Hand Surgery Associates, and $92.00 for the evaluation performed by Dr. Komnick. These medical expenses total $1,924.00. These bills shall be paid pursuant to the medical fee schedule of prior agreement whichever is less as set forth in Section 8.2 of the Act. Should it be shown that any of these bills or portions of these bills have already been paid by the Respondent, Respondent shall receive credit for those payments.

In support of the Arbitrator's decision with regard to the amount due for temporary total disability, the Arbitrator makes the following conclusions of law:

Based upon the foregoing discussion, the Arbitrator finds Petitioner's alleged period of temporary total disability, from November 1, 2014 through November 5, 2014, representing 5/7 weeks to be supported by the record. This finding is based upon the testimony of the Petitioner and is supported by the medical evidence presented in this case. The Respondent offered no evidence to refute this testimony or medical evidence.

The Petitioner testified that when she came under the care of Dr. Sam Biafora, he released her to perform sedentary work only and the police department provided her with work within those restrictions. However, after the Respondent received the report from their evaluating physician; Dr. Bryan Neal who provided an opinion that the Petitioner's left wrist condition was not causally related to the incident that occurred on August 11, 2014, the department refused to continue to provide her with light duty work effective November 1, 2014.

The Petitioner then saw Dr. Biafora on November 5, 2014 and even though he recommended a surgical procedure to her left wrist, she convinced him to release her to perform full duty work as a police officer. She then returned to work for the Respondent on November 6, 2014. (PX #2 & #3) The Respondent offered no evidence that the Petitioner was offered light duty work during this period of time or that any physician released the Petitioner to return to full duty work as a police officer during this time period.

Based upon the above, the Arbitrator finds that the Petitioner is entitled to 5/7 weeks of temporary total disability benefits for the time period commencing November 1, 2014 through November 5, 2014.

In support of the Arbitrator's decision with regard to whether the Petitioner is entitled to prospective medical care, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the Petitioner is entitled to the prospective medical treatment recommended by her treating physician Dr. Biafora. This determination is based upon the testimony of the Petitioner relating to her continued symptoms, the opinion of Dr. Biafora and the opinion of Respondent's evaluating physician, Dr. Neal who also opined that a surgical procedure would be appropriate if the Petitioner's symptoms and her inability to perform activities warranted it.

The Petitioner testified that despite the course of treatment she received to her left wrist, she continues to experience a sharp pain in her left wrist with certain movements and a dull, constant pain that is manageable when wearing her splint. She also experiences a constant stiffness in her left wrist. To control these continued symptoms she uses ice frequently and over the counter medications. The Petitioner testified that she would like to have the surgical procedure done as recommended by Dr. Biafora but she could not do so because she would miss time from work while recovering from the surgery and did not have enough accrued sick days to be paid for the time off work.

Dr. Biafora in his most recent examination of the Petitioner performed on February 25, 2015, recorded that the Petitioner continued to complain of ulnar sided left wrist pain. His examination on that date disclosed tenderness and increased pain with a TFCC grind test. Based upon this information and examination, he continued to recommend an arthroscopy to Petitioner's left wrist. (PX #3) Also, during his evidence deposition, Dr. Biafora continued to recommend this surgical procedure to Petitioner's left wrist. (PX #4; p.23)

The Respondent's evaluating physician; Dr. Bryan Neal opined in his evidence deposition that the Petitioner may have a tear of the TFCC because her complaints and clinical presentation are consistent with a TFCC injury and ulnar instability. He then opined that in order to repair a TFCC injury you would need to perform a surgery either arthroscopically or in an open fashion and the need for the surgery would be based upon the degree of Petitioner's on-going symptoms and her ability to perform activities. (RX1; p.54-56, 77)

Based upon the above, The Arbitrator finds that the Respondent shall be responsible for the authorization of and payment for the surgical procedure to Petitioner's left wrist as recommended by Dr. Sam Biafora.

ORDER OF THE ARBITRATOR

The Respondent shall pay the Petitioner temporary total disability benefits of $813.25 per week for 5/7 weeks, from November 1, 2014 through November 5, 2014, as provided in Section 8(b) of the Act, because the injury sustained caused the disabling condition of the Petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

The Respondent shall pay the unpaid medical bills, which were for reasonable and necessary medical services of St. Alexis Medical Center, Hand Surgery Associates and Center for Sports Ortho pursuant to the Medical Fee schedule or by prior agreement, whichever is less as provided in Section 8(a) and 8.2 of the Act.

The Respondent shall authorize and be responsible for the payment of the surgical procedure to Petitioner's left wrist as recommended by Dr. Sam Biafora in order to attempt to repair the TFCC injury and/or, to repair and correct the distal ulnar instability which has been found in Petitioner's left wrist.

Deborah L. Simpson — June 19, 2015

Signature of Arbitrator — 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

Genaro Garcia,
Petitioner,

vs.

Labor Solutions,
Respondent.

16IWCC0428

NO: 11 WC 5912

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 28, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,100.00. 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: JUN 24 2016
o6/22/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0428

GARCIA, GENARO
Employee/Petitioner

Case# 11WC005912

LABOR SOLUTIONS
Employer/Respondent

On 8/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.20% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0786 BRUSTIN & LUNDBLAD LTD
CHARLES E WEBSTER
10 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

1872 SPIEGEL & CAHILL PC
CHRISTINA BAWCUM
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

16IWCC0428

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

GENARO GARCIA
Employee/Petitioner

v.

LABOR SOLUTIONS
Employer/Respondent

Case # **11** WC **05912**

An *Application for Adjustment 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 **March 4, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0428

FINDINGS

On **December 4, 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, in part,*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$15,747.68**; the average weekly wage was **$302.85**.

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 **$490.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$490.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$220.00/week** for **1 6/7 weeks**, commencing 12/5/2010 through 12/17/2010, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$220.00**/week for **35** weeks, because the injuries sustained caused the **7% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent is entitled to a **PPD credit** in the amount of **$81.46** due to an overpayment of TTD benefits.

Petitioner's claim for prospective medical is denied.

Petitioner's claim for penalties and fees is denied.

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

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

Signature of Arbitrator

August 25, 2015
Date

AUG 28 2015

FINDINGS OF FACT

At the start of the trial, Petitioner amended the Application for Adjustment of Claim to name the correct employer, Labor Solutions, as the Respondent. (ArbX 2) An Order allowing said amendment is being entered contemporaneously with this Decision.

Petitioner testified via an interpreter.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on December 4, 2010. He was working as a temporary employee at Cloud Packaging, packing boxes. A fellow employee placed a spray can on the oven near where Petitioner was working and the can exploded, striking petitioner in the face and causing him to fall back against a wall. Petitioner felt pain in his hip and low back and had a cut on the left side of his face from his nose to his cheek.

After the accident, Petitioner was taken to Lutheran General Hospital. He presented with a complaint of major trauma via EMS. It was recommended that he be screened from an electric shock perspective along with evaluation for physical trauma. Multiple CTs including the head/brain, C-spine, and facial bones were recommended for evaluation. Tetanus and laceration repair were also recommended. (PX 3)

On December 4, 2010, a CT of the maxillofacial bones revealed (1) no acute fractures (2) hematoma, subcutaneous gas and a laceration seen within the tissues overlying the left maxilla. There were subtle old minimally displaced fractures of the nasal bones. A CT of the cervical spine revealed no acute cervical spine injury. A CT of the head/brain revealed (1) no acute intracranial abnormality and (2) linear occipital and parietal skull fractures which were of indeterminate age. (RX 3)

On December 5, 2010, a repeat CT of the head or brain was performed. The impression was no acute intracranial abnormality and there was no change regarding the parietal and occipital fractures. Petitioner was cleared by neurosurgery. (PX 3, RX 3)

Petitioner was discharged from Lutheran General on December 6, 2010. He was instructed to keep the wound clean and dry and his sutures were to come out in the trauma clinic. (PX 3)

Petitioner returned to Advocate Lutheran General Hospital on December 13, 2010. It was recommended that Petitioner return to the trauma clinic at Lutheran General on December 17, 2010. In addition, it was recommended that Petitioner present to Dr. Butler for clearance to return to work as it relates to his spine. (PX 3)

Pursuant to the recommendations of the doctors at Lutheran General, Petitioner presented to Dr. Jesse Butler on December 16, 2010. It was noted that Petitioner was involved in a work related injury on December 4, when an aerosol can exploded in his face causing him to be thrown backwards and falling onto his buttocks. He had significant laceration and burn to the left side of his face. He has complained of low back pain since the date of injury. On physical examination, Petitioner had no radicular symptoms to the lower extremities. Dr. Butler recommended physical therapy and that Petitioner return to work at light duty with a 10 pound lifting restriction. (RX 2)

Petitioner followed-up with Lutheran General Outpatient Department on December 17, 2010. Petitioner's sutures were taken out, and it was recommended that he see an oral surgeon. He was to follow-up as needed and it was also noted that he was released to light duty work, per the spine doctor. (PX 3)

Petitioner returned to work at light duty as of December 18, 2010.

Petitioner next saw Dr. Butler on January 6, 2011. It was noted that he was in physical therapy and continued to complain of low back pain 9/10. He denied radicular symptoms of the lower extremities. He had been working with a 10 pound lifting restriction. The impression was lumbar sprain and strain. Dr. Butler recommended that Petitioner continue physical therapy and continue working with the previous work restrictions. (RX 2)

Petitioner initially presented to Loyola Oral Health on January 31, 2011. Dr. Jordan recommended comprehensive testing. This was to be done at the next visit, as Petitioner had failed to timely appear for the January 31 visit. (RX 1)

On February 3, 2011, Petitioner informed Dr. Butler that his back pain had significantly improved. He had been discharged from physical therapy and discontinued all pain medications. The impression was lumbar sprain/strain. Dr. Butler felt that Petitioner had reached maximum medical improvement, and Petitioner was released to return to work regular duty without restrictions. (RX 2)

Petitioner returned to Dr. Jordan at Loyola Oral Health on February 9, 2011. The exam revealed no lesions or soft tissue pathology noted of tongue, FOM, gingiva or buccal mucosa, moderate staining and calculus noted throughout especially mandibular anterior and interproximinally throughout, oral hygiene assessment was poor, needed improved flossing and brushing, multiple enamel fractures/craze lines extending from teeth #7-15, tooth #4 had completely fractured lingual cusp, tooth #14 had fracture through amalgam restoration, and #15 was fractured/missing amalgam restoration, other caries noted were #2-O, #8-M, #9-M, #12-D, #17-O, #18-MOB, #30-O. Radiographs revealed periapical radiolucencies associated with teeth #5, 7, 8, and 12, widened PDL #10, horizontal root fracture of #9, caries #5-M, #12-D, #14-D, #18-D (cervical caries). Petitioner was tested for vertical root fractures on teeth #4-15 with no teeth showing signs of vertical root fracture. Teeth #4, 5, 7-10, 12, 14, 15 were all percussion sensitive. Due to the location of root fracture, #9 was non-restorable and needed extraction. Teeth #5, 7, 8, and 12 needed root canal treatment plus core plus crown. The presence of percussion sensitivity on teeth #10, 14, and 15 suggested that root canal treatment may be needed on those teeth in the future. The doctor wanted to re-evaluate for pulp vitality before completing definitive treatment. (RX 1, page 2)

On March 17, 2011, Petitioner complained of recent severe tooth ache. He informed Dr. Jordan that he went to an outside dental clinic where he was told that he has an infection and was prescribed Amoxicillin. Petitioner reported that he felt relief after a few days and stopped taking pills. Dr. Jordan recommended that he finish the remainder of the prescription. Dr. Jordan explained to Petitioner that the treatment plan is still the same. He was scheduled with Dr. Patel for start of root canal therapy on #14. Dr. Jordan informed Petitioner that he may need to be referred to an endodontist for treatment of #5, depending on complexity. (RX 1, page 4)

On March 21, 2011, Dr. Patel removed the existing amalgram from #14, the caries were excavated using dental instruments and carbide burs, the appropriate retentive preparation completed, sound dentin and enamel tooth structure obtained, there was no exposure to pulp chamber, matrix band and wedge placed around tooth #14, IRM restorative material placed in preparation, matrix band and wedge removed, occlusion checked and no premature contacts noted. Dr. Patel explained to Petitioner that he would evaluate his maxillary teeth at next visits in order to better assess their vitality. This meant pulpal and periapical testing at successive visits in order to assess final recommendations. Petitioner was aware that sensitivity may arise from tooth #14. At the next visit, the plan was possible root canal therapy on #14 or other teeth pending vitality testing. (RX 1, page 5)

On March 25, 2011, the diagnosis was tooth #14, pulpal: necrotic, periradicular: symptomatic apical periodontitis. Dr. Page recommended root canal of #14, post and core buildup/crown #14. The root canal on #14 was begun on that date. (RX1, page 6)

Petitioner returned to Dr. Patel on April 5, 2011, for continuation of care on #14. Likewise, April 12, 2011, petitioner presented to Dr. Patel for continuation of care. Also, other teeth were evaluated for root canal treatment. (RX 1, pages 6-8)

On April 19, 2011, Dr. Patel recommended root canal therapy by an endodontist. They were to remove caries and restoration, and place temporary restoration at the next visit. (RX 1, page 9) On May 17, 2011, Dr. Patel performed excavation of #15. (RX 1, page 10)

On June 23, 2011, Petitioner was asking why his referral has not been sent to an endodontist for his workers' compensation case. After discussing case with Sandy, the surgical coordinator, she felt it would be best for case to be transferred to attending dentist so attending could file an evaluation of what may have been related to work injury.

Petitioner returned to Loyola Oral Health on June 28, 2011. Radiographs taken that day revealed periapical radiolucencies on teeth #7,8,9,10,12, 14, and 15. Examination performed showed some mobility, pain to palpation and incisal and occlusal fractures on teeth #7, 8, 9, 10, 12, 14, 15. It was recommended that Petitioner undergo root canal treatment followed by post and core, and crowns for cuspal protection. (RX 1, page 11)

On August 22, 2011, Petitioner presented to Dr. O'Donnell of Endodontis, Ltd. Petitioner complained of pain off and on in the area of #14 and 15. Dr. O'Donnell noted that root canal treatment has been completed on #14 and a temporary has been placed on #15. The dental exam also revealed horizontal fractures of the clinical crowns #7-#10. All teeth (#7, 8, 9, 10, 12, 14, 15) were percussion tender. Multiple teeth were either cold sensitive or did not respond to cold at all. Anterior teeth (#7-#10) were all chewing sensitive. Tooth #11 was the only tooth that responded within normal limits. Dr. O'Donnell agreed with the proposed treatment that teeth #7, 8, 12, and 15 require root canal therapy. Tooth #10 was listed in treatment plan of February 11, 2011, and was also in need of root canal treatment. Due to horizontal fractures in two places of #9, it was recommended that it be extracted. The root canal treatment on tooth #14 looked well done. Dr. O'Donnell concluded that the injured workers' current regimen of dental care was reasonable for the injuries sustained on December 4, 2010. He felt that the injured area and subsequently treated teeth should have a good prognosis. (RX 4)

Petitioner presented to Dr. Wanda Cruz-Gonzalez of Loyola Oral Health on September 14, 2011. He presented for root canal treatment on #7, 8, 10. Treatment was initiated and they were to continue root canal therapy on #7, 8, and 10 at the next visit. (RX 1, page 12)

Petitioner returned to Dr. Cruz-Gonzalez for obturation of root canal therapy of teeth #7, 8, and #10 on January 26, 20112. At the next visit they were to do root canal therapy on #4 and #5. (RX 1, page 12) On February 7, 2012, Petitioner returned to the dental clinic for crowns and core #7, 8, 10, and obturation. (RX 1, 12)

Petitioner returned to Dr. Cruz-Gonzalez on February 8, 2012, for root canal treatment on teeth #4, 5, and 12. Access was performed on all three teeth but #5, which presented a vertical fracture. Due to this, the tooth could not be restored. Extraction was recommended followed by bone graft. Also, implant placement, abutment and implant crown. (RX 1, 12)

On February 22, 2012, Petitioner presented to the oral clinic for crowns and core of teeth #7, 8, and #10. At the next visit they were to place crowns on #12, 14, and final implant for max interim partial denture. (RX 1, 13)

On February 29, 2012, Petitioner returned to Dr. Loyola Oral Health for crowns and core teeth #12, 14, and interim max partial denture. At the next visit they were to do surgical extraction teeth #5 and #9 followed by bone graft and delivery of interim partial denture. (RX 1, 13)

Petitioner had no treatment for the remainder of 2012 and had no treatment in 2013.

On March 13, 2014, two years after the last visit, Petitioner saw Dr. Pischeck at Loyola Oral Health for comprehensive oral exam. He reported that he was not taking any medications. Petitioner stated that he was seen over two years ago for dental treatment. He stated that he was no longer experiencing any discomfort or pain. Due to lack of time and complication of Petitioner's case (multiple teeth to be extracted and replaced/crowned), Petitioner was informed that FMX and alginate impressions were to be made that day so Dr. Pischek could review them. FMX made, as well as MAX and MAND alginate impressions. He was to return to OHC dental clinic for prophylactic treatment and comprehensive exam. After review of radiographs and casts, the following treatment was proposed: Extraction of #4, 5, 9. Post & Core of #7, 8, 10, 12, 29. Crown of #7, 8, 10, 12, 14, 15, 29. Implant of #4, 5, 9, 13. Implant Crown of #4, 5, 9, 13. (RX 1, page 14)

Petitioner has had no further treatment.

Petitioner testified that he currently has no face pain. He has pain in his teeth (front teeth and his eye tooth on the left side. The amalgam just fell off. There is a hole in his tooth. His back is very painful. He has terrible pain. His entire back goes numb. It is difficult for him to turn around. He currently works in a restaurant doing dishwashing. He had headaches that felt like migraines. Sometimes Petitioner forgets stuff. He takes Ibuprofen daily for his pain complaints. Sometimes he has blackout like episodes. Petitioner testified that he had treatment for his headaches at the Walgreens at Pulaski and Lawrence and got prescriptions from a government doctor at Roosevelt and Lawrence (Not in Chicago !). He had records from this doctor, but he didn't bring them to trial.

Petitioner filed a §8(a) and Penalties Petition on September 18, 2013, seeking the extraction of #5 and implant replacement. (PX 4A, 4B) Respondent replied with several letters advising that the procedure would be approved and paid for if Petitioner scheduled treatment promptly. (RX 5) Petitioner claimed that he was unable to set up an appointment because of a language barrier and later Loyola told him to talk with his attorney. The matter was set for trial on Respondent's motion for a trial date certain. Petitioner initially disputed that nature and extent was in issue, but then chose to close proofs, maintaining that a PPD award concurrent with an order for prospective medical was appropriate.

Petitioner testified that he perhaps would want additional treatment at Loyola, so that his teeth can be fixed.

CONCLUSIONS OF LAW

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

With regards to issue (F), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator concludes as follows:

The Arbitrator finds that Petitioner's current condition of ill-being (status post facial laceration, lumbar sprain/strain resolved after appropriate conservative care and PT, and multiple dental trauma) is causally related to the injury, based upon the testimony of Petitioner and the medical records.

The Arbitrator notes that petitioner denied prior back injuries, facial injuries, or injuries to his teeth. The medical records establish a prior nasal and perhaps facial fracture, with the likelihood of a prior skull fracture and very poor dental hygiene.

The Arbitrator does not find that Petitioner's "headache" and blackout complaints are related to the injury, as there are no supporting medical records for this portion of the claim and Petitioner's testimony fails to support any such claim.

With regards to issue (H) Petitioner's age, and issue (I) Marital status, the Arbitrator concludes as follows:

Petitioner claimed on the Request For Hearing that he was 41 years old and married with 4 dependant children on the date of accident. (ArbX 1) The Application states that Petitioner was born in 1959, was single and had no dependants under the age of 18. (RX 6) Petitioner identified his signature on the Application and the medical records list the patient's birthday as being September 19, 1959, the same date set forth on the Application. The various medical histories also consistently identify the patient's age as being 51.

Petitioner claimed on cross-examination that his wife left him and that is why he said he was single on the Application. He also said that he had 4 children, but he never identified them, stated their ages, or provided any supporting documentation for these claims.

The Arbitrator holds Petitioner to his allegations on the Application and he is found to have been 51 years old and single with no dependants on the date of accident.

With regards to issue (L), What is the nature and extent of the injury, the Arbitrator concludes as follows:

Given the Arbitrator's finding regarding causal connection above and the medical records, the Arbitrator finds that the injuries caused the 7% loss of use of a person as a whole.

Petitioner's testimony regarding ongoing back complaints, headaches and blackout symptoms is not credible, especially since he obtains prescriptions from a government doctor located at a nonexistent intersection in the City of Chicago. Regardless, Petitioner did suffer facial and dental trauma and a sprain/strain of the lumbar spine that resolved with appropriate conservative care and PT. The Arbitrator believes that this PPD award is appropriate, given the Record as a whole.

With regards to issue (M), Should penalties and fees be imposed upon Respondent, the Arbitrator concludes as follows:

Respondent's disputes in this case are found to be in good faith and any claim by Petitioner for penalties and fees is found to be without merit.

With regards to issue (N), Is Respondent due any credit, the Arbitrator concludes as follows:

The Parties stipulated that petitioner was temporarily and totally disabled from work as a result of the accident from December 5, 2010 to December 17, 2010. This is 1-6/7 weeks. There was no evidence of the 3 working day waiting period, so the agreed upon time is awarded.

The TTD rate is $220.00. 1-6/7 weeks at $220.00/week is $408.54. Respondent paid $490.00 in TTD. There is an overpayment of TTD in the amount of $81.56, which should be applied to the PPD award herein.

With regards to issue (O), Other-Prospective Medical, the Arbitrator concludes as follows:

Prospective medical is not awarded.

Petitioner did not follow through on the treatment that was offered by Respondent (See: RX 5). His testimony at trial was that perhaps he would want additional treatment at Loyola. Petitioner did not seek follow-up dental care for some 2 years between February of 2012 and March of 2014. Then he did not schedule treatment after the March, 2014 visit. He blamed his failure to follow through on a language barrier (the Arbitrator is not persuaded that Loyola would not communicate with Petitioner in Spanish), although he thinks that his cousin scheduled the March, 2014 visit and instructions from Loyola to consult with his attorney.

Given the above, and the Record as a whole, including the inconsistencies in Petitioner's testimony, the Arbitrator finds that Petitioner is not entitled to prospective medical care.

STATE OF ILLINOIS)
) SS.
COUNTY OF Mc LEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Fisher,
Petitioner,

vs. NO: 13 WC 09654

16IWCC0429

Corn Belt Energy Corp.
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, casual connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof..

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 9, 2016, is hereby affirmed and adopted.

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: JUN 24 2016

Joshua D. Luskin

o-06/07/15
jdl/wj
68

Ruth W. White

16IWCC0429

DISSENT

I must respectfully dissent and would find that Petitioner has met his burden of proof that his right shoulder rotator cuff tear was causally related to a work injury on November 30, 2012. Petitioner testified that he was bending thick wire to fit into an electrical box during most of his shift. At the end of the workday he felt pain in his right shoulder and asked a co-worker to assist him in finishing the work that day. The following morning, Petitioner testified that he didn't notice the pain as much so he played basketball with some friends. When he awoke the next day, he had pain in his shoulder and could hardly raise his arm.

In his January 13, 2014 record, Dr. Dustman wrote that Petitioner sustained an injury to his right shoulder on November 30, 2012, when he was bending a 2" diameter wire and felt a very specific tingling in the shoulder with subsequent pain. Dr. Dustman noted that he reviewed the actual wire, which is very large and heavy, and would require a lot of upper extremity force to bend. Dr. Dustman opined that this mechanism of injury is "very compatible with an injury to the rotator cuff." Dr. Dustman reiterated that he "felt very strongly...that this was work related." Dr. Dustman testified that Petitioner's degenerative condition was aggravated to the point of becoming symptomatic as a result of his work activities on November 30, 2012. He believe that Petitioner would have been able to play basketball with a torn rotator cuff because Petitioner had only tore one of the four tendons and would have been able to function.

Respondent's Section 12 examiner, Dr. Johnson testified that Petitioner's condition was likely degenerative that occurred over time and that the activity Petitioner engaged in of repetitively bending wire would not typically be an activity that would cause a rotator cuff tear. He did not believe that Petitioner could have had an acute rotator cuff tear from bending wire and then have been able to play basketball the next day. However, on cross-examination, Dr. Johnson examined the kind of wire that Petitioner was bending. (Rx7; Deposition Exhibit Px1). He agreed that it was stiff and that the shoulders would be involved in the process of bending it. He admitted that bending that wire could have increased the symptoms of a pre-existing condition.

I find the opinion of Petitioner's Dr. Dustman to be more persuasive than that of Dr. Johnson on the issue of causation. The Commissioners examined the kind of wire that Petitioner was bending. I note that it was very heavy and could hardly be bent using significant strength. Dr. Dustman had examined the wire and found that it required a lot of upper extremity force to bend and was consistent with a rotator cuff injury. Even Dr. Johnson admitted that bending this wire could have increased the symptoms of a pre-existing condition.

I would find that Petitioner's work activities on November 30, 2012, were the cause of Petitioner's condition of ill-being and, based on the opinion of Dr. Dustman, that the basketball game the following day was not an intervening injury that broke the chain of causation.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FISHER, ROBERT
Employee/Petitioner

Case# **13WC009654**

CORN BELT ENERGY CORP
Employer/Respondent

16IWCC0429

On 6/9/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0651 LAW OFFICE OF MIKE McELVAIN
223 E FRONT ST
BLOOMINGTON, IL 61701

0264 HEYL ROYSTER VOELKER & ALLEN
VINCENT M BOYLE
PO BOX 6199
PEORIA, IL 61602

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

Robert Fisher
Employee/Petitioner

Case # **13** WC **9654**

v.

Corn Belt Energy Corp.
Employer/Respondent

16IWCC0429

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Bloomington**, on **April 21, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 30, 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 an alleged accident ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**77,072.80**; the average weekly wage was $**1,482.77**.

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 shall be given a credit of $**9,881.10** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**9,881.10**.

Respondent is entitled to a credit of $**29,944.98** for group disability payments, and $**40,454.22** for group healthcare benefits paid, under Section 8(j) of the Act.

ORDER

Petitioner's claim for compensation is denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

June 3, 2015
Date

JUN 9 - 2015

16IWCC0429

FACTS:

The Petitioner filed an Application for Adjustment of Claim alleging a specific injury to his right shoulder as a result of bending and shaping wire on November 30, 2012. The Petitioner testified that he was a 37 year employee of the Respondent and that he has been a journeyman lineman since 1991. The Petitioner testified that his job duties as a journeyman lineman required him to climb poles, work with high-voltage wires, perform overhead and underground construction, drive trucks, and dig holes. The Petitioner's description of his job activities is consistent with the Job Description submitted into evidence as Respondent's Exhibit 2.

The Petitioner testified that on November 30, 2012, he was bending thick wire to fit into an electrical box during most of his shift, as he had done the day before. The Petitioner testified that at the end of the work day on November 30, 2012, he felt pain in his right shoulder and had to ask a co-worker to assist him to finish out the work that day. He testified that his co-worker "finished up" for him and, at the end of the shift, he went home and took a shower. The Petitioner testified that he then went to a party where he had some drinks and that he took some Ibuprofen when he got home from the party. The Petitioner did not seek any medical treatment that day nor did he report the occurrence to the Respondent that day.

The Petitioner testified that the following morning, which was a Saturday, he played basketball with some friends and that, after playing basketball, his shoulder and arm hurt more. The Petitioner testified that he went to bed that evening and, when he awoke the following day, Sunday, he had pain in his shoulder and he could hardly raise his arm. The Petitioner testified that he went into work the next day, Monday, December 3, 2012, and reported the alleged injury of November 30, 2012. The Petitioner testified this was the first time he reported the work injury to the Respondent.

The Petitioner testified that he was unable to work on December 3, 2012, so he sought medical treatment. The Petitioner was seen that day by Jennifer Effler, APN, with OSF Medical Group. During this visit, the Petitioner complained of right shoulder pain for the past three days. He reported his right shoulder became stiff on Friday night and that he took some Ibuprofen and felt somewhat better. He also reported playing basketball on Saturday with no problem, and then on Saturday night, he was unable to raise his hand. No mention of any work activities or a work injury occurring on November 30, 2012 is contained in the record of that visit. X-rays of the right shoulder were taken and noted to be unremarkable except for some degenerative changes of the acromioclavicular joint. The Petitioner was diagnosed with right shoulder pain and rotator cuff dysfunction. He was prescribed pain medication and an MRI was recommended, along with a referral to an orthopedic surgeon.

An MRI of the Petitioner's right shoulder was performed on December 11, 2012 and was reported to show moderate tendinopathy of the supraspinatus tendon, a partial thickness tear at the anterior and lateral insertion of the supraspinatus tendon, and severe osteoarthritis at the acromioclavicular joint.

The Petitioner was then seen by Dr. Anthony Dustman with Orthopedic & Sports Enhancement Center on December 13, 2012. Dr. Dustman noted a previous rotator cuff repair he had done on the Petitioner's left shoulder in 2000. The Petitioner was noted to report that his right shoulder pain started at work on November 30, 2012 after bending wire for two days at work. The Petitioner reported that he felt a very specific tingling in his shoulder and a lot of pain, for which he took Ibuprofen. The Petitioner also reported that he played basketball the next day and had a marked increase in pain. Dr. Dustman noted the MRI, which showed an extensive tearing of the supraspinatus tendon, and he recommended a decompression and likely repair of the rotator cuff. Dr. Dustman performed this procedure, which consisted of a mini rotator cuff repair and biceps tenotomy, on March 30, 2013. The MRI did not demonstrate a SLAP lesion, but this was found during the arthroscopy.

Following surgery, the Petitioner underwent a course of physical therapy and continued to follow up with Dr. Dustman. On October 31, 2013, the Petitioner was noted to be 23-weeks post-op and doing very well. He had good range of motion and his strength was improving. Dr. Dustman declared the Petitioner at maximum medical improvement and released him from treatment.

The Petitioner testified during arbitration that he currently continues to experience some popping and grinding in his right shoulder and that his strength is not where it used to be. The Petitioner also complained of having trouble sleeping. The Petitioner followed up with Dr. Dustman for these symptoms on December 5, 2013. Dr. Dustman noted excellent range or motion and strength, and noted the Petitioner was back to work. Due to the Petitioner's concerns, Dr. Dustman ordered updated X-ray images and an MRI of the right shoulder. The X-rays were unremarkable and the MRI did not show any retear. Dr. Dustman was satisfied and reiterated that the Petitioner had reached maximum medical improvement. Dr. Dustman noted that the Petitioner could continue working and do activities as tolerated. This was the Petitioner's last visit with Dr. Dustman regarding this injury.

The Petitioner testified that he returned to his regular full duty work in October of 2013 and has continued working for the Respondent without issue since that time. He testified he is not taking any pain medication and is able to complete his job duties. He further testified his wages were the same as they were prior to the injury.

At the request of the Respondent, the Petitioner was seen and examined by Dr. Brent C. Johnson with Midwest Orthopaedic Center on January 30, 2013. Dr. Johnson spoke with the Petitioner regarding his condition and his reported work injury. He reviewed the Petitioner's medical history, along with the related medical records, and performed a physical examination. During this examination, the Petitioner discussed the basketball game he played in the day after the alleged work injury. The Petitioner reported he did not use his right arm significantly when playing basketball as he is left-handed and it was not a very intense game. He reported that after the basketball game, he could no longer lift or raise his arm and he had an increase in pain.

Following his examination, Dr. Johnson diagnosed the Petitioner with a significant partial

thickness or small full thickness supraspinatus rotator cuff tear based on his review of the MRI. He opined the Petitioner's work activities on November 29, 2012 and November 30, 2012 were likely not related to the Petitioner's right shoulder condition. He noted rotator cuff tears are a common disorder of middle-aged patients. He cited medical literature indicating that individuals older than 50 are likely to have rotator cuff tears or degenerative arthritis of the shoulders. He also noted rotator cuff tears rarely occur from an acute injury. With regard to the Petitioner specifically, he opined that the mechanism of repeatedly bending wire would unlikely cause an acute significant tear of the rotator cuff. He further noted that if the Petitioner had an acute tear, it would have been unlikely he would be able to recover enough within 24 hours to play basketball the following day. He also noted the Petitioner symptoms appeared to worsen much more significantly following basketball than they did spending two day bending wire.

Dr. Johnson's treatment recommendations were consistent with the course of treatment recommended by Dr. Dustman; however, he opined that the need for surgery was unrelated to the Petitioner's work activities on November 30, 2012.

The evidence deposition of Dr. Dustman was taken on October 9, 2014. Dr. Dustman testified to his treatment of the Petitioner, which was consistent with the medical records. Dr. Dustman testified the Petitioner reported a very specific injury occurring on November 30, 2012 when he was bending 2" diameter wire when he felt a very specific tingling in his shoulder with subsequent pain. Dr. Dustman opined that the Petitioner's right shoulder condition was related to the Petitioner's work activities. He acknowledged the Petitioner had degenerative findings on the x-rays and MRI, but testified he believed the Petitioner's degenerative condition was aggravated to the point of becoming symptomatic as a result of his work activities on November 30, 2012. He further testified that the various job duties that the Petitioner engaged in as a journeyman lineman were related in aggregate to the Petitioner's injury, despite the specific versus repetitive nature of the alleged work injury. When asked on cross examination whether the Petitioner would have been able to play in a basketball game with a torn rotator cuff, Dr. Dustman testified that the Petitioner only tore one of the four tendons and would have been able to function.

The evidence deposition of Dr. Johnson took place on January 28, 2015. Dr. Johnson provided an analysis of the Petitioner's medical history, his review of the Petitioner's job description, and his examination of the Petitioner, which took place on January 30, 2013. His testimony was consistent with his narrative report. He testified that he diagnosed the Petitioner with a rotator cuff tear, which was consistent with Dr. Dustman's diagnosis. When asked about the MRI findings, he testified he could not rule out a chronic or acute injury based solely on the imaging studies, but testified he agreed with the interpretation of the radiologist that the findings appeared to be more chronic, age-related changes. He further noted the severe osteoarthritis of the AC joint. With regard to causation, Dr. Johnson testified that the mechanism of injury was not consistent with a rotator cuff tear. He testified that the bending of wire would be unlikely to cause or contribute to an acute tear to the rotator cuff. He testified that rotator cuff tears are more commonly caused by degenerative processes/changes, but he did not think the work activities would contribute to this. Dr.

Johnson further testified he did not think the work accident aggravated the condition, and that it would be unlikely for the Petitioner to recover enough to play basketball the very next day. It was his opinion the cause of the rotator cuff tear was the Petitioner's degenerative condition, evidenced by the chronic findings on the MRI. With regard to the tingling feeling the Petitioner reported feeling on November 30, 2012, Dr. Johnson testified this is not in itself indicative of a rotator cuff tear; it could be referred pain or some kind of condition in the shoulder. Dr. Johnson opined that the Petitioner's rotator cuff tear was not related to the alleged injury of November 30, 2012, or the Petitioner's work activities.

CONCLUSIONS:

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

The Petitioner has alleged a specific injury to his right shoulder as a result of bending wire on November 30, 2012. He testified during arbitration that he was bending 2" diameter wire and felt a specific tingling in his shoulder. As a result of this injury, he testified he was unable to continue the task and required a coworker to complete it for him. He did not report the injury to anyone that day and did not present the coworker as a witness to testify on his behalf.

The Petitioner testified that he did not seek immediate medical treatment for his alleged work injury. He testified that he went home, he showered, he attended a going away party, he went to bed, and when he woke up the following morning, he played basketball with his friends. He even testified he was feeling fine the day after the alleged accident. It was not until after this basketball game that the Petitioner sought medical treatment or reported the alleged work injury to his employer.

The Arbitrator cannot ignore the fact that the Petitioner did not report his alleged injury or seek medical treatment on the day his alleged injury occurred, which was a Friday. He then played basketball the day after the alleged work injury. While he testified that his shoulder and arm hurt more after he played basketball, he testified that it wasn't until the next day, Sunday, that he was unable to move and/or raise his arm. The Arbitrator notes that markedly increased symptoms following the basketball game are consistently reported in all the medical records submitted into evidence. When asked specifically on cross examination regarding the basketball game, the Petitioner indicated his right arm was still bothering him and he purposely did not use his right arm significantly during the game. This seems to contradict earlier testimony when the Petitioner testified he woke up feeling fine after taking Ibuprofen the night before. Further, the Petitioner testified he participated in a number of various maneuvers during the game which require the use of both hands and arms, such as passing, catching, shooting, and playing defense. Based on the foregoing, the Arbitrator questions the

credibility and reliability of the Petitioner's testimony and finds that the Petitioner's injury more likely resulted from or was aggravated by the basketball game.

This is further evidenced by the deposition testimony of both Drs. Dustman and Johnson. Both doctors acknowledge the Petitioner had pre-existing, degenerative findings in the right shoulder. Dr. Dustman testified to his causation opinion and indicated it was based on the Petitioner's reported twinge or tingling episode on November 30, 2012. However, based on his own analogy provided in earlier testimony, if the Petitioner did tear his rotator cuff on November 30, 2012, whether as a result of specific injury or cumulative trauma, he would likely have had onset of symptoms, such as pain, difficulty moving, and/or inflammation, the *next day* or shortly after the incident. This was not the case. The Petitioner testified he felt fine the next morning; fine enough to play in a game of basketball with his friends. It was not until the day after the basketball game that the Petitioner had an onset of severe symptoms, and it was not until after the basketball game that the Petitioner sought medical treatment and reported the alleged injury to his employer.

Additionally, the Arbitrator notes that the opinions of Dr. Johnson are credible and persuasive on the issues of accident and causation. He testified that bending the wires was not a proper mechanism of injury to cause a tear of the rotator cuff. He also testified the Petitioner's condition of ill-being was likely degenerative in nature and pre-existing, and supported this opinion with objective medical evidence (the diagnostic imaging) and medical literature. He further testified that if the Petitioner's rotator cuff tear developed, either acutely or from an aggravation on November 30, 2012, the Petitioner would not likely have been able to play basketball on December 1, 2012.

It is axiomatic that the bears the burden of proving all of the elements of his claim by a preponderance of credible evidence. Relying on the Petitioner's own testimony, the records submitted into evidence, and the opinions of Dr. Johnson, the Arbitrator finds that the Petitioner has failed to prove he sustained an accident that arose out of and in the course and scope of his workplace activities with the Respondent on November 30, 2012, or that his condition of ill-being was causally related to his employment by the Respondent. Accordingly, the Petitioner's claim for compensation is denied and no benefits are awarded herein. Determination of the remaining disputed issues is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald A. Kolasinski,
Petitioner,
vs.
University of Illinois,
Respondent,

NO: 06WC006797

16IWCC0430

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 8, 2015, is hereby affirmed and adopted.

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

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

The party commencing 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: JUN 2 7 2016
MJB//bm
o-6/21/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOLASINSKI, RONALD A
Employee/Petitioner

Case# **06WC006797**

16IWCC0430

UNIVERSITY OF ILLINOIS
Employer/Respondent

On 8/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.20% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0208 GALLIANI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 825
CHICAGO, IL 60602

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

2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTINE JAGODZINSKI
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

0902 UNIVERSITY OF IL/CLAIMS MGMT
1737 W POLK - M/C 940 SUITE B9
CHICAGO, IL 60612

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

AUG 28 2015

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

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 A.Kolasinski
Employee/Petitioner
v.
University of Illinois
Employer/Respondent

Case # 06 WC 06797

16IWCC0430

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **December 3, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0430

FINDINGS

On **November 11, 2005**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**75,267.92**; the average weekly wage was $**1,447.46.**

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, in part,*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $ **61,057.61** for TTD, $**- 0-** for TPD, $**- 0 -** for maintenance, and $**- 0 -** for other benefits, for a total credit of $ **61,057.61** .

Respondent is entitled to a credit of $**9,289.60** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$964.97/week** for **67 5/7 weeks** commencing **11/12/05 – 10/22/06 and 1/8/09 – 4/19/09 and 3/5/12 – 3/31/12** as provided under Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$591.77/week** for **275 weeks** because the injuries sustained caused the **55% loss of person as a whole** as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner medical expenses of **$2,253.60,** pursuant to Section 8(a) of the Act. In addition, Respondent will hold Petitioner harmless for claims of reimbursement of $9,289.60 by the group carrier, pursuant to Section 8(j) of the Act.

Respondent shall Pay Petitioner all accrued compensation benefits from **11/11/2005 through 12/3/2014** and shall pay the remainder of the Award, if any in weekly 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

August 28, 2015
Date

AUG 28 2015

FINDINGS OF FACT

Petitioner was employed by Respondent since March of 1987. He has been a plant operating engineer since 1989. He was a member of Local 399. His job duties consisted of maintaining and repairing all aspects of the heating, ventilating and air conditioning, vacuum pumps and refrigeration equipment of 45 – 50 buildings in the University of Illinois Medical Complex. He described his work as heavy physical labor. It required him to perform lifting of items up to 100 lbs; bending; squatting; kneeling and climbing ladders. He was on his feet all day long. Since the hospital complex covers a large geographic area, his job duties required him to walk approximately 8 miles per day. He had to carry his 25 pound sack of hand tools with him.

After graduating from high school, Petitioner served in the United States Marine Corps for two years. After being honorably discharged, he worked for approximately 10 years rebuilding engines. He then earned a certificate in plant operation engineering from City Colleges in 1985.

Petitioner described his prior state of health as good. The only known medical condition prior to the date of the accident was atrial fibrillation, for which he was under the care of a doctor and taking medication. It did not interfere with his day-to-day activities. He never injured or received medical treatment to his left leg or left shoulder prior to November 11, 2005.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on November 11, 2005. Petitioner was

inspecting the ventilation system in the ceiling of a dental office in one of the University's medical buildings. He was on the 5th rung of a stepladder when it collapsed. He fell to the ground landing on his left shoulder, twisting his left leg and hitting his head causing the loss of consciousness. When he regained consciousness, he noticed severe pain and his left leg was bent backwards. EMT's transported him via ambulance.

Petitioner was brought to the University of Illinois-Chicago Hospital emergency department. His left knee was x-rayed and a CT scan of his head was performed. He was diagnosed with "severe fracture of the proximal tibia and head trauma." The emergency room doctor told Petitioner that the hospital was not equipped to handle a case such as his and he must be transported to the nearest trauma center. (Pet. Ex. 1)

Petitioner was then transported to Cook County Hospital (now known as Stroger Hospital) where he was admitted from November 11, 2005 through November 19, 2005. He was placed on pain medication and his left leg was put in traction. An examination was conducted by an orthopedic surgeon, who adviseded that he would not be able to perform the complicated surgery necessary to reconstruct his left leg, but he knew of a doctor who could perform the procedure: Dr. Virkus of Rush Presbyterian Hospital. Arrangements were made to transfer Petitioner to Rush Presbyterian Hospital for treatment by Dr. Virkus. The discharge diagnosis from Cook County Hospital was left tibial plateau fracture. (Pet. Ex. 2)

Petitioner was admitted to Rush Presbyterian Hospital from November 19th through November 30, 2005. Dr. Virkus proposed a surgery whereby the 22 broken pieces of his lower leg and knee joint be reconstructed by means of plates, wires, screws. Petitioner agreed to the

surgery. It was performed on November 23, 2005 and consisted of an "open reduction with internal fixation bicondylar tibial plateau fractures." (Pet. Ex. 3)

After being discharged from Rush Hospital on November 30, 2005, Petitioner was transferred to Bowman Rehabilitation Center, a part of the Rush Presbyterian Complex. He remained in that facility until December 10, 2005, undergoing post-operative treatment as well as occupational therapy. He was discharged from that facility in a wheelchair. (Pet. Ex. 3)

When he arrived home, Petitioner convalesced in a hospital bed placed in his family room for approximately one month. In the ensuing months, he alternated between the hospital bed and the wheelchair. A home health nurse and physical therapist came to his house to assist in his recovery.

Petitioner's first post-operative visit with Dr. Virkus was on December 13, 2005. He spoke to Dr. Virkus not only about his leg but also his left shoulder. Dr. Virkus thought that the leg injury was of more critical importance than the shoulder but he would treat to the shoulder as the leg improved. (Pet. Ex. 4)

Petitioner began attending outpatient physical therapy at Pro Rehab in April of 2006. He received therapy for both the left leg and left shoulder. The range of motion in his left leg initially improved, but then plateaued. Dr. Virkus recommended an additional surgery, which was performed on June 1, 2006. It consisted of a "left knee arthroscopic lysis of adhesions and manipulation under anesthesia." Following this procedure, Dr. Virkus recommended and performed a third surgery on June 22, 2006. This procedure consisted of a manipulation of the left knee joint under general anesthesia and intra-articular cortisone injections. (Pet. Ex. 4)

Petitioner thereafter underwent physical therapy and began to show improvement. When seen by Dr. Virkus on August 17, 2006, Petitioner was able to ambulate, albeit with an antalgic gait. An injection was administered and a future surgery consisting of plate removal was discussed. Petitioner was allowed to return to work with a light duty restriction of three days per week with walking and standing limited to 4 hours per day, no climbing of ladders or lifting over 20 lbs. Petitioner contacted his supervisor, Jim Almeida, and inquired regarding light duty week. He was told that there was no light duty work available. He continued to receive physical therapy.

On September 27, 2006, Petitioner returned to Dr. Virkus who noted that the patient "wants to return to work." Petitioner was released to return to work with the restriction of no ladders or scaffolds as of October 23, 2006. (Pet. Ex. 4)

Petitioner returned to work and noticed that significant left knee joint swelling had returned. He returned to Dr. Virkus on November 1, 2006, but continued working while receiving occasional injections to the left knee throughout the ensuing year. Petitioner continued to notice pain in both the left knee and the left shoulder.

On November 6, 2007, Petitioner was seen by Dr. Virkus' partner, Dr. Anthony Romeo, for examination of his left shoulder. Dr. Romeo diagnosed left shoulder impingement and AC joint arthrosis. He recommended surgery to the left shoulder. It was scheduled for March of 2008 but cancelled due to an unrelated illness. The procedure was performed on January 8, 2009 consisting of a left shoulder arthroscopy, acromioplasty, coracoacromial ligament release and distal clavicle resection. (Pet. Ex. 4) Petitioner underwent post-operative physical therapy

and was released to return to work on April 8, 2009, without any specific restrictions regarding the left shoulder.

Petitioner thereafter returned to work, but began noticing renewed pain in his left knee. He returned to Dr. Virkus on May 20, 2009 and it was noted that Petitioner had lost further range of motion in his left knee and there was more crepitus with range of motion. X-rays revealed post-traumatic arthritis. Dr. Virkus offered hardware removal and it was left to Petitioner to determine when he wanted to undergo the procedure. Petitioner returned to Dr. Virkus on December 7, 2011 and stated he was willing to undergo the fourth procedure on the knee. Surgery was performed on March 4, 2012 and consisted of removal of deep hardware in the left lateral knee with closed manipulation of the left knee. (Pet. Ex. 3) After undergoing further physical therapy, Petitioner was released to return to work on March 31, 2012.

On returning to work, Petitioner continued to notice problems with his left knee. When he returned to Dr. Virkus on April 11, 2012, knee flexion was reduced even further to 100 degrees. An injection was administered. Performing work duties such as kneeling and squatting were causing significant problems. Petitioner returned to Dr. Virkus on July 25, 2012 and Dr. Virkus imposed permanent light duty restrictions of no ladders or scaffolds, no lifting over 50 lbs., and no kneeling or squatting. (Pet. Ex. 6)

Petitioner requested, through his attorney, that Respondent provide him with vocational rehabilitation. (Pet. Ex. 7) Respondent never offered any assistance in finding a job or offered him light duty work. Petitioner has looked for work within his restriction through his union

and various sources, but has not found any work within his restrictions. Petitioner applied for and received regular retirement benefits, effective July 1, 2012.

At the present time, Petitioner notices pain and swelling in his left knee and lower leg every day. His knee is stiff and he can only flex it to 90 degrees. He walks with a limp. He is able to walk for approximately one block before he begins to notice significant pain in the left leg. If he is sitting in the car for more than an hour, he must stop and stretch his leg out. Petitioner drove to the trial on December 3, 2014 and walked to the Thompson Center from the parking lot. The trip took 1 to 1 ½ hours. He notices particular difficulty walking stairs and must sometimes walk them one at a time. He also notices increased problems with weather changes. He takes Aleve almost every day for the pain and will wear a brace on his knee when he knows he has to be on his feet for any amount of time.

Petitioner last saw Dr. Virkus in March of 2013 and underwent an injection. He plans to return to Dr. Virkus intermittently for injections which help his condition. He also plans to return to Dr. Virkus for a total knee replacement because he has been told it is inevitable.

The Arbitrator inspected the Petitioner's left leg at trial. Left knee swelling was apparent to the naked eye. He had two scars each approximately 12" in length, running down the lateral and medial aspects of the lower leg, distal to the knee joint. The plate that was surgically implanted on the medial side remains: the plate on the lateral aspect of the leg was removed.

With respect to the left shoulder, Petitioner continues to notice pain and stiffness in the shoulder. He has difficulty raising his left arm overhead and with lifting activities. With respect to maintenance of his home, he has hired a lawn service to mow his grass. He had to

hire painters to paint portions of his home. He has been unable to travel on airplanes because he cannot sit for long periods of time. No physician restricted Petitioner from airplane travel. He no longer plays tennis.

Petitioner was examined at the request of Respondent by orthopedic surgeon, Dr. David Raab, on February 6, 2013. The physical examination revealed, among other things, 5 – 10 degree extension deficit of the left knee and left shoulder flexion to only 100 degrees. X-rays showed evidence of post-traumatic degenerative arthritis of the left knee and it was "just about bone-on-bone in the medial compartment." There were degenerative changes in both the medial and lateral compartments along with early degenerative changes at the patellofemoral joint. Dr. Raab diagnosed post-traumatic degenerative arthritis of the left knee. Petitioner's current condition was related to the work injury. Dr. Raab recommended continued palliative treatment consisting of anti-inflammatory medications, cortisone injections and viscosupplemenatations. Ultimately, he will require a total knee replacement. With respect to the permanent light duty restrictions, Dr. Raab agreed that the restrictions imposed by Dr. Virkus on July 25, 2014 were appropriate. Since Petitioner has post-traumatic degenerative arthritis, there was limited range of motion, so squatting and kneeling will be extremely difficult. (Pet. Ex. 8)

John Gilmartin testified that he was the chief operating engineer for Respondent. He said that the job of a plant operating engineer is to keep the heating and cooling systems operational. The operating engineer is on his feet almost the entire day and must kneel, squat

and lift heavy objects. To Gilmartin's knowledge, only two individuals who were plant operating engineers ever had light duty restrictions that were accommodated by Respondent.

CONCLUSIONS OF LAW

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

With respect to issue (F) "Is petitioner's current condition of ill-being causally related to the injury?" the Arbitrator concludes the following:

The Arbitrator finds that Petitioner's current condition of ill-being with respect to his left leg and left shoulder are causally related to the work accident, based upon the unrebutted testimony of Petitioner and the medical records, including the report of Dr. Raab.

With respect to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?" the Arbitrator concludes the following:

Petitioner offered into evidence six medical bills: Cook County Hospital in the amount of $19,970 for dates of service 11/12 – 19/2005; West Loop University Medicine in the amount of $700 for dates of service 11/20 – 22/2005; Rehab Associates of Chicago $690 for dates of service 11/28 – 30/2005; University of Illinois Medical Center in the amount of $5,640 for date of service 11/11/2012; Ambulance Transportation Inc. in the amount of $550 for date of service 11/19/2005; Medical Express Ambulance Service in the amount of $850 for date of service 11/11/2005. The Arbitrator finds these bills all to be reasonable and necessary and causally related to the work injuries.

With respect to the Cook County Hospital bill, the group carrier made payments in the amount of $8,700 and the remaining charges have been adjusted to a zero balance. No amount is due and owing. However, the Respondent will hold the petitioner harmless for claims for reimbursement by the group carrier in accordance with §8(j) of the Act.

With respect to the bills from West Loop University Medicine, Rehab Associates of Chicago and Ambulance Transportation Inc., they were paid Respondent, as evidenced by the Claims Summary – Payments (Resp. Ex. 2). No amount is due and owing on this bill.

With respect to the bill from the University of Illinois Medical Center in the amount of $5,640, the bill has been paid in part by Respondent, as evidence by the Claims Summary – Payments (Resp. Ex. 2) in the amount of $3,386.40. The Arbitrator awards the outstanding balance of $2,253.60.

With respect to the Medical Express Ambulance Service, in the amount of $850, this charge has been paid in part by the group carrier in the amount of $589 and in part by Respondent through the workers' compensation in the amount of $291, as evidenced by the Claims Summary – Payments (Resp. Ex. 2). Therefore, no amount is outstanding. However, Respondent will hold Petitioner harmless with respect to claims for reimbursement by the group carrier, in accordance with §8(j) of the Act.

With respect to issue (J) "What temporary benefits are in dispute (TTD)?" the Arbitrator concludes the following:

The Parties stipulated that Petitioner was temporarily and totally disabled as a result of the injuries for a period of 67-5/7 weeks. Respondent has paid 63-2/7 weeks, so an additional $4,283.29 in TTD is owed to Petitioner.

With respect to issue (L) "What is the nature and extent of the injury?" the Arbitrator concludes the following:

Petitioner sustained a profound injury to his left lower extremity, resulting in the fracturing of his tibial plateau and fibula into 22 pieces requiring a complicated ORIF reconstruction with plates, wires and screws and then three subsequent surgical procedures. At the present time, Petitioner has severe restriction of motion of the knee, daily pain and swelling, and walks with a limp. Both Drs. Virkus and Raab confirm that Petitioner will require a knee replacement in the future. With respect to Petitioner's shoulder injury, he continues to experience pain, weakness and stiffness in the shoulder. Dr. Raab found that he was capable of only 100 degrees of flexion. Petitioner's testimony regarding daily pain and swelling as well as his limitations regarding activities of daily living was credible and fully supported by the objective medical evidence.

The testimony of both Petitioner and John Gilmartin confirmed that his job as a plant operating engineer required heavy lifting, kneeling, squatting, climbing ladders and extensive walking. Both Drs. Virkus and Raab agree that Petitioner is no longer capable of performing these essential duties of his job. Despite a request from Petitioner to assist in locating work within the restrictions, Respondent has not provided such assistance, or offered to accommodate his current restrictions. Petitioner chose to retire.

Petitioner impressed the Arbitrator as being a hard working individual who enjoyed his trade. He would return to work if he was physically capable of doing so.

The Arbitrator finds that Petitioner has sustained the complete and permanent loss of use of the man as a whole to the extent of 55% thereof as a result of the injuries sustained.

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

Waldemar Ramotowski,

Petitioner,

vs. NO: 11WC 028508

ARRP Trucking and Paving,

Respondent,

16IWCC0431

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 November 3, 2015, is hereby affirmed and adopted.

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

16IWCC0431

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

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

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

DATED: JUN 2 7 2016
MJB/bm
o-6/21/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

RAMOTOWSKI, WALDEMAR
Employee/Petitioner

Case# **11WC028508**

16IWCC0431

ARRP TRUCKING AND PAVING
Employer/Respondent

On 11/3/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1938 BELCHER LAW OFFICE
MATTHEW J BELCHER
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Waldemar Ramotowski
Employee/Petitioner
v.
ARRP Trucking and Paving
Employer/Respondent

Case # 11 WC 28508

16IWCC0431

An *Application for Adjustment 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 **January 13, 2015 and January 15, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **7/14/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**96,076.76**; the average weekly wage was $**1,676.00**.

On the date of accident, Petitioner was **51** 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 $**79,813.09** for TTD benefits and $**13,915.60** for an advance on permanency, for a total credit of $**93,728.69**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**1,117.33**/week for **183** weeks, commencing **7/15/2011** through **1/15/2015**, as provided in Section 8(b) of the Act.

Pursuant to Section 8(a), Respondent shall pay Petitioner the total of the unpaid medical bills for the reasonable, necessary, and related medical services in the amount of $**86,525.63**, subject to Section 8.2 of the Act.

Respondent shall authorize and pay for the L4-5 lumbar decompression surgery prescribed by Mark Sokolowski, M.D., and the left total knee replacement prescribed by Ronald Silver, M.D., pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner $**480.00** (**$80.00 x 6 visits**)for the out-of-pocket medical expense reimbursement for office visits to Dr. Nowak for the dates of 7/18/11, 7/25/11, 8/18/11, 9/7/11, 9/19/11, 10/14/11, subject to Section 8.2 of the Act. (Px. 1)

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

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

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

Signature of Arbitrator

November 2, 2015
Date

NOV 3 - 2015

ICArbDec19(b)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Waldemar Ramotowski,
Employee/Petitioner.

v. Case No.: 11 WC 28508

ARRP Trucking and Paving,
Employer/Respondent.

16IWCC0031

STATEMENT OF FACTS

Petitioner's Testimony:

The petitioner, Waldemar Ramotowski, testified via a Polish interpreter, that for the last twenty years he has lived on the southwest side of Chicago with his wife and now three children.

The petitioner is a U.S. Citizen but was born in Poland in 1959. He finished formal schooling, which consisted of vocational school in agriculture, at the age of 17 or 18. His occupational history in Poland was limited to farm work. (Tr. of 1/13/2015, p. 74)

When the petitioner arrived in the United States in 1986, he started working at a restaurant making pizzas and washing dishes. Thereafter, he began working for the respondent, ARRP Trucking and Paving, and continued working there for over twenty years until his accident of July 14, 2011. (Tr. 75-76)

ARRP Trucking and Paving puts asphalt in parking lots. (Tr. 75-76) The petitioner's first job for the respondent was as a laborer. (Tr. 75) However, approximately four years prior to July 14, 2011, he began working as an operating engineer for the respondent and became a member of IUOE Local 150. (Tr. 76)

The petitioner's work for the respondent is very heavy work. He used a jackhammer, pneumatic hammer, sledgehammer, pick, shovel and hand roller. The job required rolling over asphalt with the roller, fixing sewers and lifting manhole covers. The petitioner identified the photograph that was presented to him as one that fairly and accurately depicts the type of hand roller he used in July of 2011. Such hand roller is comprised of two-inch thick steel or iron. He used such roller to flatten asphalt next to a fence. (Tr. 78-79, Px. 15)

In 2010, the petitioner injured his back when he was working on a sewer in a parking lot. When he and his co-workers were lifting a cast iron piece, he felt pain in his back. He could say that he saw stars in his eyes due to the pain. He thought that he had overstretched his muscles

at that time. Following that back injury, the petitioner went to his family doctor who referred him to Dr. Zoboski for massages. On his sixth or seventh visit to Dr. Zaboski, he felt good enough to go back to work and returned to full-duty work. The petitioner did not hire a lawyer or file a workers' compensation claim for the 2010 injury. (Tr. 80-81)

In July 2011, the petitioner took the larger truck to the job site next to a church on Roosevelt Road in Chicago. The petitioner then testified to the following:

Q: What happened next?

A: So we were removing some of those tools for work, and we also were removing the roller. So my assistant, he went on top of the truck and he grabbed the handle as you could see on the picture and I grabbed the rest of it, the bottom of it.

We were putting it down. And at that time, I felt pain, terrible pain in my back and it felt like somebody was putting a knife, and I had this crunch noise in my knee and my whole leg started to hurt at that time. For a moment, I just stood there and I do not know how long. Eventually I started slowly working.

* * * * *

Q: And if you had the larger truck, were you able to leave the job site with the truck?

A: No. The boss told me to go home.

Q: How did you get home?

A: I called my wife, and my wife came and picked me up.

Q: What was the name of the person who told you to go home?

A: Tom Pozeol (phonetic).

* * * * *

Q: Did you leave the job site before your co-workers?

A: Yes.

* * * * *

Q: Was your boss aware that you were leaving?

A: He told me so because I complained about my back. Initially, he wanted me to go to another job site.

Q: And then when this conversation took place, that was about what time?

A: At the job site around three.

Q: And when you say "at the job site," this is on Roosevelt Road next to the church?

A: Yes. There in the parking lot. (Tr. 84-88)

The petitioner further testified that he saw his family doctor, Waldemar Nowak, four days later. It took him four days to get in to see Dr. Nowak. He told Dr. Nowak about the work accident. Dr. Nowak speaks Polish. (Tr. 88)

Dr. Sokolowski speaks Polish. (Tr. 88-89)

When he saw Dr. Goldberg at the request of the insurance company, he was provided with a translator. (Tr. 89)

When he saw Dr. Cole at the request of the insurance company, he was not provided with a translator. The petitioner also testified that Dr. Cole did not ask him how the accident happened. (Tr. 89)

Prior to the July 14, 2011, the petitioner did not have any problems with his left knee, did not receive any medical treatment for his left knee and was not prevented from working due to any left knee problem. (Tr. 90)

The petitioner further testified that since the date of accident, he has not been able to go back to work because of the pain in his back and leg. He hopes that they will fix his back and leg so that he can return to work. (Tr. 91)

The petitioner testified that it was his understanding of Dr. Nowak's test on July 25, 2011 that he could not bend his left knee the way he can bend his right knee. (Tr. 92)

Dr. Nowak sent him to see a neurosurgeon, Dr. Yapor. (Tr. 92-93)

The petitioner further testified that his understanding of the current treatment plan is that Dr. Silver told him he needs a knee replacement and Dr. Sokolowski told him he needs surgery on his back. These surgeries have not been scheduled. (Tr. 93-94)

Dr. Sokolowski gives his pain medicine but when he runs out of the medicine, he cannot walk. Sometimes he needs a cane to walk. He does not have a cane with him on the date of the trial. He walks slowly. There are days in which he cannot walk normally. (Tr. 95)

The petitioner testified that in 2013, 2014, 2015, it has been getting worse. On his worse days, he still feels "that knife" being inserted into his back and the same thing with his leg. (Tr. 95-96)

The petitioner testified that he thinks that, slowly, he would have been able to lift 20 to 30 pounds. He testified that, slowly, he can take a window out of a wall and set it down. He testified that, slowly, maybe, he would be able to walk up a large flight of stairs. He can use a drill, but if he would kneel, he would not be able to get up - -he would need someone to help him up. He can go to the grocery store, slowly, and go to his doctor's office. He drives his daughter to school, goes to church and can sometimes walks normally at church. (Tr. 96-97)

The petitioner testified that he is not at work because there are no easy jobs at work. It is heavy work and quite often he lifts heavy things. He can carry a shovel but can use the shovel for a moment. (Tr. 98)

The petitioner saw part of the surveillance video. The video shows his colleagues and their sons. The property shown is one of his friend's. This is not a job site where people are being paid; it is colleague for colleague. The video shows the petitioner going to the store and bringing back some beer. The petitioner saw where he took the window out and put it down on the ground. It took him a couple of minutes, less than five minutes to do that. The window weighed approximately 20-25 pounds. (Tr. 101-103)

Despite the fact that he could perform this window-lifting activity, he cannot go to work. Such activity only lasted only a couple of minutes while his workday is 8-13 hours long, and sometimes even longer. No one at the respondent has offered him any light-duty work. He would like to return to work for the respondent. (Tr. 103-104)

Sometimes when he visits his doctor, he has to sit in the waiting room for an hour, an hour and a half. After sitting for so long, his back and leg hurts. When he leaves, he feels terrible. He has been going to the doctor continuously since the accident. (Tr. 104-105)

The petitioner testified that other than the work accident in 2011 when he was moving the roller, there has not been any event after that accident. (Tr. 105)

The petitioner testified that there are some days when he feels better. He is not able to walk normally. He needs a cane. Nothing prevents him from returning to his old job except the pain. It hurts so much. He cannot work. He takes the pain medication quite often. On days when it really hurts, he take takes the pain medication quite often. (Tr. 106-107)

The petitioner testified to the following:

Q: Since the date of the accident with the roller, has the pain in your back gone away?

A: No. No.

Q: Has the pain in your leg gone away?

A: No. Still hurts.

Q: And how about your knee?

A: It's terrible. It really hurts.

Q: When you have pain in your knee, could you please show the Arbitrator where the pain - - where you feel it.

A: It starts here in my back and it runs all the way down to my foot. (Indicating)

THE ARBITRATOR: For the record, the petitioner is using his left hand to point to his lower back and I believe the motion was down the thigh and into the lower leg. Correct?

THE INTERPRETER: Yes. (Tr. 105-106) 16IWCC043_

On cross-examination, the petitioner testified that he applied for Social Security disability benefits about a year ago and has been receiving such benefits. (Tr. 108-110) He further testified that he takes five or six medications including Hydrocodone. He takes these pills quite often. On better days, he does not take his medication. He rarely has a better day, which would be maybe three times a month, but he does not know. He does not drink alcohol. (Tr. 11-115)

The petitioner testified from the time period soon after the accident until now, he thinks he is getting worse. He feels terrible. The pain in his knee has worsened. The pain in his back has worsened. He cannot do heavy things and cannot walk up stairs a lot. He is unable to mow the lawn or to shovel snow. When he does feel better, he drives. When he takes his medication, he is able to drive to the store, but not every day - - only when he needs to do it. He does not remember how often he drives to the store. He owns his own vehicle, parks on the street year-round and sometimes parks it in his garage. When it snows, his wife, his kids clear the snow off his vehicle and clear a path when the snow is heavy. He is able to do some things, but slowly. He takes out a small trash bag. (Tr. 116-120)

The petitioner testified that he is able to walk a block, he stops, rests a little, and then completes his walk. (Tr. 125) Without discomfort, maybe he is able to walk a block slowly after he takes his medicine. (Tr. 126-127) He does not know how far he can walk. He never tried it. He does not remember when he got his cane. He needed the cane so he bought it. He bought the cane in 2013 or 2012. He does not remember when he bought the cane. He relies on the cane quite often. On the days he does not feel right, he uses the cane. When it hurts, he uses the cane. He felt pretty well today, so he did not use the cane. He used the cane yesterday. (Tr. 125-134)

The petitioner testified that he has hobby that involves pigeons. He has 40 pigeons that he keeps in a cage. The cage measures 5' x 7' and about 7' to 10' tall. He feeds and waters the pigeons. On a better day, he slowly cleans up the pigeon area. A colleague of the petitioner's brings in the bags of bird feed. (Tr. 139-141)

The petitioner's wife works. To replace the income that he once had, the petitioner has managed to save money. He does not perform any side jobs or other work for money. He cannot do a hard labor job. (Tr. 142-143)

The petitioner is able to dress himself and perform hygienic functions, but does these functions slowly. He showers but does not know how long a typical shower lasts. He does not bring the cane into the shower. (Tr. 143-144)

When he wakes up on a typical day - - it depends - - if he feels bad, he will take his medicine. Then he takes a seat and watches television. Sometimes he watches television until he eats and sometimes he does not have a taste, so he does not. If he feels well, he will go to the store. He usually waits for his wife to get up, and then they have coffee together and talk about things. Sometimes when he feels pretty well, he will go see a colleague for a social visit. A "colleague" is a friend, but not from work. The video showed some of his colleagues. They live in the neighborhood. (Tr. 147-152)

When the petitioner referred to the larger truck, he was referring to the box truck at work. There is a lot of equipment and tools in the box truck. He had a helper named Eric. When they take the hand roller out of the truck, they always used their hands to take it down.

He hurt his back in 2010 when he and a Mexican guy were lifting something while working on a sewer in a parking lot. After he got hurt, he saw stars. He sat for a while, and then kept working throughout that day. (Tr. 153-154)

The petitioner testified that in 2011, a typical workday would last until 3:00 and maybe longer if there was more to do. He injured himself in 2011 at 7:00 a.m. when he began his workday. The first thing that they removed from the truck was the roller. They removed everything from the truck - - whatever they needed to perform the job. First they removed the tools and then they removed the roller. The petitioner worked "only" eight hours on the 2011 date of accident. (Tr. 154-155)

The petitioner did not go to the hospital on the day he hurt his back in 2011. He felt a crunch in his knee and knives in his back and he thought it was going to pass. (Tr. 156)

He did not know how the roller got back on the truck. On the date of the accident, between the time he was hurt and the time he left work at 3:00, he did everything, but slowly. He drove the large, steamroller, he used the hand roller on asphalt and he used a shovel to dig something. Tom Pozeol did not arrive at the job site until 3:00. (Tr. 156-157)

The petitioner testified that he thought the whole thing was going to pass, but it did not and that is why he went to see the doctor. His wife called the doctor on the day that he went to see the doctor. (Tr. 157-158)

If he is not hurting as much, he does not use the cane. (Tr. 158-159)

The petitioner testified earlier that when he waits to see the doctor, sometimes he sits in the office for an hour to an hour and a half. Sitting is difficult and he has to wiggle himself to feel a little relief. The pain scale changes for those times. He will shift in his seat because he cannot sit straight. When he is sitting, it hurts and when he walks, it hurts. When he goes to see the doctor, he usually feels bad, and after he sits and waits for the doctor, he feels worse. He does not sit for a long time and watch TV. (Tr. 163-164)

He has this radiating pain coming down from here and going through my leg to my foot. It feels like an electrical current going through his leg. But the biggest issue is his knee. It hurts inside his knee but also all around the knee. The petitioner testified that so far, he does not have any problem with his right knee. (Tr. 164-166)

The petitioner testified that when he hurt himself while lowering the hand roller, he began to feel pain when he was placing the roller. The petitioner demonstrated how he had to bend over to set down the hand roller. He testified that he had to bend down much more to place the roller at that time than he was bent down for the demonstration. The roller was not damaged as a result of this incident. It is made of steel. (Tr. 167)

Testimony of Mark Sokolowski, M.D.:

Dr. Sokolowski was called to testify in this case. He speaks Polish and English.

In his practice, he sees about 2,000 patients a year and he performs 200 spine surgeries per year.

Dr. Sokolowski is board-certified in orthopedic surgery and his surgical practice is limited to the spine.

Dr. Sokolowski first saw the petitioner on January 4, 2013 and last examined him on October 10, 2014. At the first visit, the history taken was that the petitioner was in his usual state of health working in the course of his usual occupation when on July 14, 2011, he was removing a hand roller from a truck with his partner. Dr. Sokolowski believed the hand roller to weigh 400 pounds and had no idea how the petitioner lifted the object. (Tr. 44) The petitioner developed an acute onset of lumbar pain with radiation to his bilateral buttocks as well as cervical pain with radiation to his periscapular regions. This accident was reported to his supervisor but he continued to work. When he was unable to continue, he was sent home due to his pain. The petitioner's primary care physician then evaluated him. Upon examination, the petitioner's symptoms persisted and included lumbar pain with radiation to his legs bilaterally, including his left buttock and left leg more than his right.

Dr. Sokolowkski reviewed the actual films of the MRI of the petitioner's lumbar spine dated July 29, 2011 and the MRI of his left knee dated December 7, 2011. Regarding the lumbar MRI, at the L4-5 level, as identified on T2 weighted axial image No. 14 of 20, Dr. Sokolowski testified that there was a clearly-seen L4-L5 disc herniation with resultant nerve impingement – "It's pressing on the nerves at that level." (Tr. 22)

Dr. Sokolowski has found that his best outcomes are from patients with nerve pain, who are "more easily curable ... so we look for a nerve pinching etiology of his symptoms." (Tr. 22-

23) Dr. Sokolowski opined that only the petitioner's current low back condition with resultant lower extremity problems are related to the reported work accident of July 14, 2011. (Tr. 38, 58)

This witness testified that the petitioner has a triangular-shaped spinal canal similar to about 15-25 percent of the population versus a round spinal canal. Because the area of a triangle is one half base times height and the area of a circle is π times the radius squared, a circular canal has more reserve space for the spinal cord that a triangular shaped canal. So because the triangular canal has a smaller area, a herniation has a greater propensity to pinch, especially in the lateral recesses.

Dr. Goldberg had only the opportunity to view MRI films of 2011 and only saw Mr. Ramotowski in 2012. Dr. Sokolowski testified that he has seen the petitioner over the course of almost two years, was able to review the MRI films of 2011 and 2014, and observe the epidural steroid treatment outcomes, none of which were apparently provided or reported to Dr. Goldberg.

Dr. Sokolowski testified that in order to correctly diagnose the petitioner's present condition and determine if he is an operative candidate in 2015, an orthopedic surgeon would need to assess the patient's *current* level of lumbar radiculopathy.

If a patient has lumbar radiculopathy rather than merely back pain, the patient would be more likely to get improvement from a surgical intervention directed at the site of the neural impingement.

Dr. Sokolowski has ruled out a lumbar strain or sprain as the correct diagnosis because such a condition would have resolved itself by this time and would not have brought about pain radiating into the leg. Dr. Sokolowski has confirmed his diagnosis with straight leg raise testing for the last two years which reproduces the leg pain because the sciatic nerve runs down the leg and it is tethered with the canal at the site of the herniation. The examination tests that Dr. Sokolowski used to clinically correlate symptomology from a herniated disc as opposed to a strain were all dependent upon the petitioner's report, and the each of the responses, individually, is within the petitioner's control. (Tr. 49-51, 53-54)

Dr. Sokolowski further correlated his diagnosis with the two lumbar epidural steroid injections, which provided good short-term benefits. Absent a disc herniation at L4-L5, those shots could not have given the petitioner any incremental relief whatsoever. Thus the diagnosis is further validated through those interventions.

Dr. Sokolowski testified that initially the petitioner was able to cope without narcotic pain medicine but that there has been clinical deterioration and he has most recently been utilizing Norco Hydocodone to control his pain.

Dr. Sokolowski is of the opinion that the petitioner is a candidate for a lumbar decompression, bilateral hemilaminectomy at L-4-L5, which is an unroofing of the spinal canal which takes the pressure off the nerves at that level and removing the disc material impinging upon his nerves. Of the 200 surgeries Dt. Sokolowski has performed each year, 75% of them are directed at the lumbar spine. So, he performs 150 lumbar procedures and they generally have a decompressive component, if they are not performed exclusively for the purpose of decompression.

The basis for his opinion that the petitioner requires spine surgery is that we are now three years from the inciting injury and if the condition were to have spontaneously resolved it would have done so by now, the MRI findings, the clinical correlation of symptoms and the diagnostic component of the epidural steroid injections.

Dr Sokolowski testified that, absent surgery, the petitioner's prognosis will remain the same—he will be limited in his ambulation, he will have a disability parking placard, he will be functionally limited, he will require narcotic analgesics indefinitely and he will not be able to return to a competitive workplace environment. (Tr. 28)

His prognosis with surgery is about 90 percent successful, i.e., nine out of ten patients have a good to excellent outcome and he will then be expected to have an improvement in the ability to stand and walk, which would make him more functionally employable than he is today.

Dr. Sokolowski is of the opinion that the outcome of the back surgery would be better if done in conjunction with the knee surgery because a critical component of post-operative rehabilitation is an ambulatory lower extremity-strengthening program.

He opined that if the petitioner has persistent knee pathology, he is less likely to be able to realize the benefits of the post-operative rehab plan. (Tr. 32)

Without surgery, Dr. Sokolowski opined, the petitioner would be limited in his walking, would require narcotics "indefinitely" and would be unable to return to a competitive workplace environment. (Tr. 28) Dr. Sokolowski testified that in his serial examinations of the petitioner, he always observed the petitioner's consistently altered gait to the left. (Tr. 48) Nevertheless, if Dr. Sokolowski observed the petitioner walking in a normal manner, his opinions would not be altered. (Tr. 30)

Dr. Sokolowski agreed that the petitioner has degenerative changes in his spine and that an acute trauma can cause those previously asymptomatic degenerative changes to be

symptomatic. Dr. Sokolowski agreed that such a mechanism of injury would be the removal of an asphalt hand roller from a truck, which was the inciting event described by the petitioner.

Dr. Sokolowski reviewed the chiropractic notes from the petitioner's treatment in 2010 and those records document a 100% resolution of soft tissue symptoms and a return to full duty. Thus, Dr. Sokolowski is of the opinion that there is no correlation between the 2010 injury and the present condition of the petitioner. Moreover, there are no prior medical records or history indicating any radicular complaints until after this July 14, 2011 work accident. The 2010 chiropractic records document a negative straight leg test and a diagnosis of lumbar strain.

Dr. Sokolowski was not aware of any qualified medical practitioners who examined or performed provocative clinical testing of Mr. Ramotowski in 2014. Dr. Goldberg was only provided with a 2011 MRI of the lumbar spine while Dr. Sokolowski is the only medical provider to be provided access to the 2014 MRI, which documented impingement at the L4-L5 level.

Dr. Sokolowski last saw the petitioner on October 10, 2014, at which time his low back condition remained "essentially the same", despite the treatment provided in the interim, which included narcotic analgesics for pain control. (Tr. 26-27, 55) Dr. Sokolowski recommends surgery in the form of a lumbar decompression bilateral hemilaminectomy at L4-5. (Tr. 27) Dr. Sokolowski testified, "I like to hit home-runs when I propose surgery. I've got 28 and a half more years of practice before I retire. I need to have a good reputation of outcomes from surgery." (Tr. 38)

Dr. Sokolowski opined that the petitioner is not at MMI and will not be at maximum medical improvement until after lumbar and knee surgical interventions and appropriate periods of post-operative rehabilitation. (Tr. 37) He would then be able to return to a wage-earning occupation. (Tr. 37)

Dr. Sokolowski testified that he aware of the standard of a reasonable degree of orthopedic certainty meaning "more probably true than not true", but with regard to the opinion that the claimant sustained a disc injury which requires surgery, Dr. Sokolowski's opinion is raised to the level of certainty. Not just probability. Dr. Sokolowski is certain. Certainty based upon the examinations findings corroborated by the diagnostic imaging and confirmed by the epidural injections.

Dr. Sokolowski testified that the petitioner "may have had a strain which resolved in the year and a half before he saw me." (Tr. 64)

Dr. Sokolowski agreed when asked if the petitioner had degenerative changes in his spine. (Tr. 32) Dr. Sokolowski agreed that it is not rare for the general public in a similar age group as the petitioner to have asymptomatic disc herniations, and estimated the frequency to

be about 40%. (Tr. 45) Dr. Sokolowski would not rely upon an EMG for the petitioner as a diagnostic test to confirm the existence of radiculopathy. (Tr. 47) He further opined that an EMG for Mr. Ramotowski would have a high possibility of a false negative.

Presently with respect to work status, Dr. Sokolowski finds the petitioner to be "functionally limited with respect to bending, twisting, lifting, stooping, squatting, prolonged standing and prolonged walking." (Tr. 36, 59) The doctor did not believe the petitioner could return to his usual occupation and therefore held him off work completely. (Tr. 37) He also believed this to be true since the petitioner's work accident. (Tr. 39) Dr. Sokolowski believed the petitioner was precluded from any job but could do sedentary work if his use of Norco and the resulting impact on his ability to drive did not prove to be problematic. (Tr. 60)

Testimony of Edward Goldberg, M.D.:

Dr. Goldberg testified with regard to his two Section 12 examinations of the petitioner that took place in October 10, 2011 and November 28, 2012.

Dr. Goldberg testified that he is an orthopedic surgeon who sub-specializes in the spine. 99.9% of everything he evaluates patient-wise is referable to spinal conditions. He does about 250 spine cases a year and is board-certified in orthopedic surgery. (Rx. 5, pp. 4-6, Dep. Ex. 1)

After reviewing the petitioner's medical records, including the MRI films from July 29, 2011, Dr. Goldberg concluded that the petitioner had some mild stenosis at L4-5 without any herniation. (Rx. 5, p. 9) Dr. Goldberg described the trefoil stenosis evident on the MRI as congenital in nature and in many instances asymptomatic. (Rx. 5, p. 10)

On or about October 20, 2011, after reviewing the petitioner's medical records and performing a physical examination, Dr. Goldberg concluded that Mr. Ramotowski sustained thoracic and lumbar strains as a result of the work accident on July 14, 2011. (Rx. 5, pp. 8-13) Dr. Goldberg recommended a 10-pound lifting restriction with the hope that the petitioner could resume full-duty work within a month of physical therapy, and did not feel injections were necessary because the petitioner's radicular complaints were localized to his left thigh. (Rx. 5, pp. 13-14)

Dr. Goldberg examined the petitioner a second time on November 28, 2012, and issued a report dated December 11, 2012. (Rx. 5, p.14) Dr. Goldberg reviewed additional treatment records. (Rx. 5, pp. 15-17, 21) The petitioner's neurological examination was normal, except for range of motion testing, which the doctor testified was within his control. (Rx. 5, p. 19)

Dr. Goldberg also reviewed surveillance video taken of the petitioner. Such surveillance video was taken on September 11, 12, and 13, 2012. Dr. Goldberg testified that the petitioner was seen without exhibiting pain behaviors, and walking without difficulty, as well as entering and exiting his vehicle without signs of distress. (Rx. 5, pp. 19-20) Dr. Goldberg concluded that the petitioner sustained a lumbar strain due to the accident of July 14, 2011, did not require further treatment, and could return to unrestricted work. (Rx. 5, p.20) In so finding, Dr. Goldberg noted inconsistencies between the petitioner's reported complaints and examination findings, which included compression testing. (Rx. 5, pp. 20-21) Dr. Goldberg could not correlate the petitioner's subjective complaints with the MRI findings, and as a consequence, did not feel surgery was warranted. (Rx. 5, p. 21) Dr. Goldberg felt that as of November 2012, no further treatment was needed and that the petitioner could return to work without restrictions.

Dr. Goldberg did not have access to any medical records for the years 2013, 2014 and 2015. He was not provided with the 2014 MRI of the lumbar spine.

Dr. Goldberg testified that if asked, he would have re-examined the petitioner as well as reviewed the more current medical records. However, he was never requested to do so.

Dr. Goldberg had no independent recollection of the petitioner. His notes indicate that he had a Polish translator. The history was of a work accident July 14, 2011 while working for ARRP Trucking and Paving. Dr. Goldberg believed the petitioner to be a machine operator and laborer.

The doctor indicated that the petitioner has a past history of injuring his back while lifting sewer frames. In this accident, he had to remove a hand roller from a truck when he developed low back pain.

When the petitioner first saw Dr. Goldberg, his primary concern was low back pain with numbness in the left anterior thigh, which did not radiate below the knee.

Dr. Goldberg reviewed Dr. Nowak's medical records that started on July 18, 2011. This record noted severe low-back pain radiating to the leg after lifting or pushing something heavy at work on July 14, 2011. The assessment was low back pain, leg pain and W.C. injury (back). The record indicates that the petitioner was taken off work as of that date (Rx. 5, p. 9) The petitioner was also given Flexeril and therapy was recommended.

Dr. Nowak's July 25, 2011 records indicate: "Still low back pain c radiation to both legs – worse since last visit – still problems walking due to pain." Dr. Nowak assessed the petitioner with a low back injury, low back pain c legs pain. He was then given Flexeril again, the therapy recommendation was renewed and an MRI was ordered. The petitioner had x-rays taken on July 25, 2011. Dr. Goldberg was not provided with the x-ray films.

On July 29, 2011, a lumbar MRI was taken of the petitioner. The films were provided to Dr. Goldberg. The films indicate mild disc degeneration, and at L4-5, mild lumbar stenosis, which Dr. Goldberg read as without herniation. Dr. Goldberg observed that the shape of the spinal canal was triangular or trefoil, which is a congenital condition that can become symptomatic or aggravated. (Rx. 5, p. 10)

Dr. Goldberg reviewed the medical records of Dr. Nowak from August 18, 2011 that continue to note low-back pain with left leg numbness. The petitioner was maintained off work and given Flexeril. Therapy was recommended. (Rx. 5, p. 10)

On September 7, 2011, Dr. Nowak noted no improvement.

With regard to the records he reviewed from the lifting accident prior to July 14, 2011, Dr. Goldberg reviewed some chiropractic notes, which document an injury from lifting a 400-pound manhole with soft tissue lower back pain. Those records indicate no radiation, no pain, no numbness or tingling in the lower extremities. (Rx. 5, p. 11)

On December 17, 2010, Dr. Zoboski's notes indicate that the petitioner received seven sessions of chiropractic treatment, his symptoms had resolved, he was returned to full-duty work and was placed at MMI.

On October 10, 2011, Dr. Goldberg performed a physical examination of the petitioner. The results of the examination revealed that the petitioner was in moderate distress. He was tender in the lumbar spine area at L3-4, L4-5 and T8-9. The petitioner had full cervical range of motion but decreased thoracic and lumbar range of motion.

Dr. Goldberg testified that his diagnosis of the petitioner was thoracic and lumbar strains that were caused by and related to the July 14, 2011 work accident. (Rx. 5, p. 13) Dr. Goldberg testified that the petitioner should continue to have four more weeks of physical therapy and the anti-inflammatory medication that he was prescribed. (Rx. 5, p. 13)

Dr. Goldberg removed him from his regular job duties and gave him 10-pound lifting restrictions.

On November 28, 2012, Dr. Goldberg saw the petitioner for the last time. On that date, a translator was used again. Dr. Goldberg reviewed additional records, including those of neurosurgeon Wesley Yapor, M.D.

Dr. Yapor opined that the petitioner sustained a disc herniation at L4-5 and diagnosed pain upon palpation to the lumbar area. (Rx. 5 p. 16) Dr. Goldberg only addressed the lumbar complaints, which consisted of numbness from the lower back into both lower extremities to the feet. At the second physical exam, he found the petitioner's lumbar range of motion to again be abnormal. The petitioner was again tender to palpation along the spine and had a slow gait. On that date, the petitioner exhibited a negative straight leg testing.

Dr. Goldberg testified that in his own practice he obtains a "fresh" MRI when the prior study is over 12 months old. (Rx. 5, p. 25)

Dr. Goldberg testified that if we wanted to know the petitioner's medical condition in 2014, it is true that a 2011 MRI would not be the freshest evidence of his condition. (Rx. 5, p. 25)

Dr. Goldberg has not been provided with any medical records subsequent to November 2012 and testified: "I don't know how he's doing since the last time I saw him". (Rx. 5, p. 26)

Dr. Goldberg likewise testified:

> I will say that I have no opinions referable to how he is subjectively at this point clinically.
> (Rx. 5 p. 27)

Dr. Goldberg testified that in the first exam he felt that the petitioner had sustained a back strain, had lifting restrictions of not more than 10 pounds and needed therapy. However, Dr. Goldberg testified that after his second exam, the petitioner was at MMI and could return to work fully duty. Dr. Goldberg testified to the following:

> Q. At the first examination of Mr. Ramotowski, you concluded that he had decreased range of motion?
> A. Yes, sir.
> Q. And that was the basis for your opinion that he had sustained what you thought was a lumbar sprain-strain?
> A. Yes, as well as the MRI that I reviewed.
> Q. Then you saw him a second time?
> A. Yes.
> Q. And he still had a decreased range of motion?
> A. Yes.
> Q. And so the only changes in his physical examination between the first exam and the second exam was the introduction of additional medical records as well as the surveillance video.
> A. Yes.
> Q. The additional medical records, did that help you form any opinions as to Mr. Ramotowksi's condition?"
> A. Again, the additional medical records outline what other providers had recommended. Again, I felt based on the original MRI July of 2011, my examination that he had a strain.

Q. And so that leaves us with the video, right?

A. Yes.

Q. … in the video, you said that there was (sic) three dates, the 11th, 12th, and the 13th?

A. Yes, sir.

Q. And that's all in the year 2012?

A: Yes.

(Rx. 5, pp. 33-34)

On the September 11, 2012, portion of the video surveillance, Dr. Goldberg concluded that the petitioner was not in distress because he did not observe any facial grimacing or rubbing of the affected body part. Dr. Goldberg testified that this observation was sort of a common sense, lay observation. He testified to the following:

Q. You don't need a medical opinion to determine if a person is grimacing, right?

A. No.

(Rx. 5, p. 37)

Dr. Goldberg testified that the September 11, 2012 video was not sufficient in itself to cause him to form the opinion that Mr. Ramotowski could return to full-duty work and was at maximum medical improvement. (Rx. 5, p. 39) Dr. Goldberg testified that the September 12th video was not of any medical significant other than that "he appeared in no distress" and that the September 13th video was not of any significance. (Rx. 5, p. 42)

Dr. Goldberg testified on cross-examination that the petitioner has a stenotic spinal canal at L4-5. (Rx. 5, p. 58)

Dr. Goldberg testified that while he does not think the petitioner needs surgery in this case, his stenotic spinal canal at L4-5 is a condition that can be treated surgically if that is the cause of the symptoms. (Rx. 5, p. 63)

Dr. Goldberg performs 8-12 Section 12 exams per week (Rx. 5, p. 68) and charges $2,000 for depositions. If all of the exams were charged at the rate paid in this case that would result in between $32,000 to $65,000 per month for medical legal examinations, plus between $6,000 and $10,000 additional per month for depositions. (Rx. 5, p. 69)

Dr. Goldberg testified that his opinion in this case is subjective and that with subjectivity comes the potential for bias (Rx. 5, p. 70)

Dr. Goldberg testified that trauma can cause a previously asymptomatic congenital lumbar stenosis to become symptomatic. (Rx. 5, p. 72) Dr. Goldberg testified to the following:

> Q. Do you have any opinion on how much trauma Mr. Ramotowski sustained in his lifting accident or his work accident of 7-14, 2011?
>
> A. I will say significant
>
> (Rx. 5, pp. 72-73)

Testimony of Ronald L. Silver, M.D.:

Dr. Silver is a board-certified orthopedic surgeon who limits his practice to the shoulder and the knee. Dr. Silver performs total knee replacement surgeries and performed about 200 such surgeries in the previous year. (Px. 12, pp. 1-7) Dr. Silver rendered his opinions to a reasonable degree of medical certainty. (Px. 12, pp. 7-8)

Dr. Silver had a specific memory of the petitioner and first started treating him on February 6, 2013. Dr. Silver last saw the petitioner on December 12, 2014. Dr. Silver has seen the petitioner approximately once a month for almost two years and has seen no improvement in condition. (Px. 12, pp. 20-22)

Dr. Silver testified that he first saw the petitioner "because of an injury to his left knee that he sustained at work on July 14, 2011."(Px. 12, p. 9) When Dr. Silver first saw the petitioner, he took a history. The petitioner told him that he was working full time for 25 years as a construction laborer without any restrictions or previous history of any problem with his left knee or medical treatment. (Px. 12, p. 17) On the date of the accident, the petitioner was working on a paving job and was lifting the hand roller out of the truck. He was holding the heavy roller part outside the truck and bending down to hold it and felt severe pain in his left knee as he bent the knee with the stress of the heavy roller. He tried to work the rest of the day but the pain became worse and he went home. The pain slowly worsened over time and he lost his ability to walk. (Px. 12, pp. 16-17) From the initial visit to the last visit, Dr. Silver removed the petitioner from work. (Px. 12, p. 24)

Dr. Silver performed a physical examination of the left knee and found crepitation under the kneecap and in the medial inner compartment between the shinbone and the thighbone. The left knee was swollen with effusion and he could only bend his knee to 90 degrees (a right angle) when normal a range of motion is closer to 135 degrees. Dr. Silver reviewed x-rays which showed cartilage damage down to the bone. (Px. 12, p. 18)

Dr. Silver diagnosed the petitioner with damaged cartilage of the left knee due to the accident. (Px. 12, pp. 9-10)

Dr. Silver based his opinion that the petitioner damaged the cartilage in his left knee on July 14, 2011 on the following: the lack of left knee symptoms prior to the July 14, 2011, the mechanism of injury (bending down), which is an appropriate way to crack cartilage, his clinical examination findings and the MRI scan that verified his clinical findings. (Px. 12, pp. 10-11)

He continued to hold the opinion that the injury for which Mr. Ramotowski was treating "was causally related to the work injury that he previously relayed to [him]." (Px. 12, p. 24)

Dr. Silver opined that no alternative medical procedure exists to improve the claimant's functional use of the knee as all other modalities have been exhausted including injections, extensive therapy, pain medication, anti-inflammatory medication, bracing, and assistive devices (Px. 12, p. 13) and that symptoms have not resolved after approximately one and half years of conservative care (Px. 12, p. 18). Dr. Silver opined that the petitioner has pain with activities of daily living, including just trying to sleep at night—indicating pain at rest— and the petitioner is a candidate for knee replacement. (Px. 12, p. 18)

Dr. Silver opined that a total knee replacement would "hopefully" return the petitioner to "some gainful employment." (Px. 12, p. 27) Without a total knee replacement, Dr. Silver testified, the petitioner would be permanently disabled. (Px. 12, p. 40)

Dr. Silver was aware that the petitioner also suffered a back injury as a result of the accident. Dr. Silver attempted to explain the reason that the back injury was the primary concern at the time. He opined that the back pain was more acute initially and the damaged knee cartilage was mediated by inflammation that can occur immediately or slowly. He further explained that so many times a person will say that he hurt his knee and that, hopefully, the pain will go away. Dr. Silver testified that in his many years of experience, this phenomenon is "not unusual at all." (Px. 12, p. 15)

Dr. Silver opined that back pain can alter one's gait so that one ends up stressing the knee more, which can contribute to knee pain. (Px. 12. P. 15)

Dr. Silver reviewed the medical history notes of the primary care physician, Dr. Nowak. Dr. Nowak's medical record of July 25, 2011 (11 days after the accident) indicates that the petitioner had a problem walking due to pain. Dr. Silver opined that the petitioner's problem with walking would be an example of a change in gait, which could contribute to the knee issues with which Mr. Ramotowski was diagnosed. (Px. 12, pp. 30-31) Dr. Silver acknowledged that Dr. Nowak's November 30, 2011 record indicates "knee pain" and his January 11, 2012 record indicates that the petitioner "need[s] ortho evaluation of left knee." (Px. 12, p. 31)

Dr. Silver opined that if he observed surveillance video of petitioner walking slowly, driving a car, getting in and out of his car or standing, that would not change his opinion regarding his condition or the need for a total knee replacement. (Px. 12, pp. 36-37)

Dr. Silver has treated the petitioner with pain pills, anti-inflammatory pills, and topical creams and has been waiting for approval to perform the knee replacement. (Px. 12, p. 25)

On cross-examination, Dr. Silver testified that it is unusual to find degenerative changes such as those in Mr. Ramotowski's knee in the general population of age 54. He further testified that the petitioner definitely had some pre-existing, asymptomatic degenerative changes in his knee that pre-existed his injury. The petitioner had deterioration of the articular cartilage that was pre-existing to some degree that was asymptomatic. He then had the accident that brought about further fragmentation of the articular cartilage that now goes down to the level of the bone and also has tears of the meniscal cartilage. Dr. Silver had no idea of the degree of degeneration in the petitioner's knee prior to the accident. All he knew was that there was degeneration, and then superimposed traumatic damage, and then bone on bone. (Px. 12, pp.41-44)

Dr. Silver testified that at least since February 6, 2013, the petitioner cannot work in any capacity due to the pain he experiences. He could not sit for an eight-hour shift, plus he takes narcotic pain medication. (Px. 12, p. 44)

Dr. Silver testified that the petitioner's body habitus is like a fire plug or a linebacker. He testified that Mr. Ramotowski is big, burly, barrel-chested, top-heavy with big arms and big legs, but not obese. He testified that if we were to run a BMI on him, he would be found to be in the obese range but that it would not be accurate because he is a linebacker-type of guy. He agreed with the respondent's attorney that the petitioner's body weight puts a fair amount of stress on his knee. Dr. Silver testified that we do not know what causes degeneration in the knee joint. He opined that really obese people - - 500 pounders, 400 pounders - - have a greater chance of getting arthritis. Dr. Silver would not draw the line at 300-pound individuals ending up with a lot of arthritis - - he would say that this would apply to "really big, obese people, you're talking 350, 400 pounds and beyond." (Px. 12, pp. 44-47)

Dr. Silver's opinion with regard to the mechanism of injury would not change if the petitioner only slightly bent his knees when he off-loaded the roller. Dr. Silver opined that independent of bending, shifting and turning can cause damage to cartilage. Dr. Silver testified that theoretically, a spontaneous onset of symptoms can occur, but it is not common. People have degenerative arthritis. (Px. 12, pp. 48-50)

Dr. Silver testified that he did not know when the petitioner decided to report his knee pain. What the petitioner told him was that his knee hurt immediately, but that other things were more pressing. (Rx. 12. p. 51)

Other than the MRI films of the petitioner's left knee and the radiologist's report in which he interpreted such images, Dr. Silver did not have any of the treating records of other clinicians involved in this case. Furthermore, since he first started treating Mr. Ramotowski's knee, he did not have any of the records of the treatment of the petitioner's back, although he looked at some of them during the deposition. Dr. Silver testified that he rendered opinions prior to seeing such documents and without the knowledge of the content of such records.(Rx. 12, pp. 51-52)

Dr. Silver testified that he has no opinion about the condition of the petitioner's low back. Dr. Silver's basis for his opinion that the petitioner's low back condition altered his gait and affected his knee is based on the pain the petitioner experienced. It was his understanding - - based on discussions with the petitioner - - that he had severe back pain that caused a change in his gait pattern. Dr. Silver did not remember or did not know when the petitioner's low back pain began to alter his gait pattern. Dr. Silver's understanding was that the petitioner gait pattern changed pretty early on after the accident - - days to weeks. (Px. 12, pp. 55-56)

Dr. Silver would not be surprised to learn that after his accident of July 14, 2011, the petitioner was able to work the rest of the workday. (Px. 12, p. 58)

Dr. Silver opined that the petitioner's condition has deteriorated since the accident and that he has been taking Norco since February 6, 2013. (Px. 12, p. 58)

Dr. Silver estimated that the petitioner's standing tolerance might be an hour. He opined that the petitioner is significantly reliant on a cane. He reiterated that due to the pain, the petitioner could not sit for an eight-hour day. The medication that the petitioner takes gives him some degree of pain relief. He also prescribes homeopathic patches and topical cream. (Px. 12, pp. 59-62)

Dr. Silver completely ruled out the spontaneous onset of pain in the petitioner's left knee. (Px. 12, pp. 62-63)

With regard to Dr. Nowak's July 25, 2011 note that stated "still problem walking due to pain," Dr. Silver agreed with the respondent's attorney that it is not clear from this record that it is not necessarily a reference to the knee. Dr. Silver testified that knee pain can go up the thigh and down the shin. When asked if it is significant that the November 30, 2011 record indicates the petitioner has knee pain whereas the July 25, 2011 record does not indicate knee pain, Dr. Silver testified that that would be consistent with what the petitioner told him. His knee pain got worse and worse. Dr. Silver explained that although his knee exam has not changed, his symptoms have worsened. Dr. Silver did not agree that if a clinician is rendering multiple

diagnoses, he would list the most severe diagnosis first followed by the secondary diagnosis and lesser diagnoses. The doctor testified that the distance the petitioner is shown walking would be mitigated by the petitioner's toughness. The petitioner has to live, in spite of his pain. The petitioner is a pretty stoic guy. One would not expect to see signs of discomfort if the petitioner is in severe pain. (Px. 12, pp. 64-70)

Dr. Silver opined that every activity aggravates the petitioner's symptoms, even sleeping. (Px. 12, p. 71)

Dr. Silver reiterated that there is no connection between the petitioner's body weight and the level of degeneration in his knees. (Px. 12, p. 71)

Dr. Silver pointed out that Dr. Nowak is not an orthopedic surgeon. (Px. 12, p. 72)

The doctor testified that the x-rays that he took in February of 2013 reveal a complete loss of joint space in the patellofemoral compartment and that after the permanent exacerbation, the existing cartilage fragmented into little pieces and such pieces were digested, or absorbed by the knee. (Px. 12, p. 73)

On redirect examination, Dr. Silver testified that whatever degenerative condition may have existed in the petitioner's left knee before the accident would not have been at a level that would have incapacitated him. Before the accident, he worked full time as a heavy laborer, so obviously something happened to change things quite dramatically to destroy his life as it has. The doctor's opinion is that that "something" was the work incident of July 14, 2011. Any degeneration in Mr. Ramotowski's left knee before the work injury would have been asymptomatic and became symptomatic as a result of the work injury. Dr. Silver testified that a knee condition can cause the pain to spread throughout the leg because bones grate against each other. The pain can radiate down the shin bone and up the thigh bone. Such pain might very well feel like leg pain and a layman may not pinpoint the pain specifically to the knee. From what the petitioner told him, Dr. Silver knew that between the date of accident and July 25, 2011, the petitioner was taking medication and undergoing therapy. He has not seen any of those records. The date of July 25, 2011 is the latest date from the point of the accident of which Dr. Silver was aware that the petitioner complained of leg pain. So, eleven days would have been the most time that passed between the time of Mr. Ramotowski's accident and the time he was having trouble walking and complaining of leg pain. Dr. Silver testified that before the accident, the petitioner was working full time without restrictions and bore the same body weight that he bore on December 12, 2014. From July 25, 2011 to November 30, 2011 to January 11, 2012, the petitioner's complaints became more specific toward the knee, which would be consistent with the inflammation in the knee increasing that caused the pain to focus

more on the joint itself. That would be something Dr. Silver would expect from the type of injury with which the petitioner was diagnosed. (Px. 12, pp. 76-81)

On recross examination, Dr. Silver testified that if the records from July 25, 2011 through January 11, 2012 show either an improvement in his condition or no symptoms referable to the knee, he would say that the petitioner will have good days and bad days and could even show some transient improvement and some transient worsening, but it would not change anything. If there were no symptoms referable to the leg or knee between July 25, 2011 and November 30, 2011, it may be because he came to the doctor for a different reason that day. But nothing has changed - - he injured multiple body parts so they may address one body part on one day and a different body part on another day. Dr. Silver testified that at no time since the accident has the petitioner been without pain; it has just varied from day to day. Dr. Silver speaks to Mr. Ramotowski through his daughter, who speaks English. The petitioner is not great at speaking English. The petitioner speaks to him and his daughter clarifies things for him. Dr. Silver stated that it made no sense that if, shortly before July 14, 2011, the petitioner's knee was symptomatic but due to his extraordinary toughness, he was able to work through the pain. Dr. Silver had no evidence whatsoever that the petitioner could not do his work in any manner before the injury occurred. Such a scenario is possible, but would be within the realm of possibility as the sun not coming up tomorrow. (Px. 12, pp. 81-86)

Testimony of Brian Cole, M.D.:

Dr. Cole is a board-certified orthopedic surgeon with a specialty in sports medicine, the shoulder, elbow and knee. Dr. Cole does not perform total knee replacements. (Rx. 6, pp. 4-5, 26)

Dr. Cole testified that all the opinions he is rendering during the deposition are within a reasonable degree of medical and surgical certainty. (Rx. 6, p. 12)

On June 18, 2012, the petitioner presented to Dr. Cole for an independent medical evaluation for his left knee. At that time, the petitioner gave the doctor a history of an alleged accident that occurred on July 14, 2011. Dr. Cole reviewed a cover letter that was addressed to him as well as various medical records, which included an MRI report of the left knee. Dr. Cole then conducted a physical examination of the petitioner. He noted that the petitioner was 5'9" tall and 280 pounds at that time, which he would classify as in the obese category with a BMI above 35. Dr. Cole then examined the petitioner's left knee. The doctor found the petitioner to be very hesitant to undergo the exam due to subjective complaints of pain in that he had a lot of low back pain during his examination of the lower extremities. The petitioner was very guarded during the examination. The petitioner complained of tenderness medially on the left knee.

Range of motion was very limited from 4 to 80 degrees. Manual muscle testing was normal. X-rays were taken and reviewed, which showed inner-sided arthritis and patella femoral arthritis. Dr. Cole further testified that he typically writes that when a patient obstructs his examination it means that he "can't get a good exam because they're guarding so much."

Dr. Cole's impression was the following: "left knee arthritis, nonwork-related and low back pain." (Rx. 6, pp. 1-10, 48)

Dr. Cole's basis for such impression is as follows:

> The length of time to accumulate osteoarthritis is significant, those were chronic changes on his X-ray, and there was no immediate evidence of pain right after the injury in the left knee, but rather it seemed to be low-back with radiation. So, it seems like this was an underlying condition that maybe became symptomtic during the process, but I don't think was caused or even agvated at least based upon the timeline that was provided. (Rx. 6, pp. 10-11)

Dr. Cole further testified that he did not review the actual MRI films of the left knee, but rather, the x-rays of the knee, "which were the main thing." He found the x-rays sufficient for him to determine the severity of the underlying condition. Dr. Cole opined that if the petitioner had sustained an aggravation of a pre-existing condition as a result of the accident, he would at least expect focal knee complaints immediately. The doctor opined that the petitioner had fairly dramatic left knee complaints at the June 18, 2012 examination, and reasoned that if Mr. Ramotowski had a specific injury to the knee per se, he would have expected early knee complaints. (Rx. 6, p. 11)

He recommended cortisone injections and physical therapy for the pre-existing arthritis of the petitioner's left knee. He felt that the petitioner could return to restricted work and that he did not need surgery on his left knee at that time. (Rx. 6, pp. 12-13)

Dr. Cole further testified that he conducts probably 400 IMEs per year, of which 70% are for the respondent and 30% are for the petitioner. As a treating physician, he performs 500-600 knee surgeries per year. (Rx. 6, pp. 13-14)

On cross-examination, Dr. Cole testified that there are a couple of typographical errors in his report. He testified that he took a history from the petitioner, and that it was unclear as to when the left knee pain manifested itself. As he understood it, there was no focal knee pain. The doctor testified that if the fact pattern presented to him were different, he might have to amend his opinion.

Dr. Cole testified that the petitioner speaks English. He was sure that he spoke to the petitioner at the time of the examination, but was not sure if a translator was present. He testified that the petitioner self reported that the pain in his knee happened suddenly. He also testified that if, in fact, the petitioner did have a sudden onset of focal pain at the time of the incident, he would need to reconsider his opinions.

Dr. Cole testified that he relied upon the records of Dr. Nowak, the petitioner's primary care physician, in forming his causation opinion. Dr. Nowak's records indicate no focal knee pain just general leg pain. Eventually, there was left knee pain in the record. After the left knee MRI, which was taken on December 7, 2011, we know that there was, in fact, some sort of objective disease process going on in the petitioner's leg or knee.

Dr. Cole acknowledged that in Dr. Nowak's May 14, 2012 record, he indicates that the petitioner has low back pain and leg pain. Dr. Cole testified that if the petitioner developed knee pain within close proximity to the accident - - i.e., if he identified the pain within a week or something like that - - then he would be far more likely to give causality.

He also testified that he had an opportunity to review the degenerative changes in the petitioner's left knee and found that there is pretty significant degeneration.

Dr. Cole testified that there is no indication is his Section 12 report that the petitioner told him when, if ever, pain became an issue in his left knee. He relied primarily, if not exclusively, on the medical treatment records from the time of the accident until the time he saw the petitioner. (Rx. 6, pp. 29-30)

Dr. Cole further testified that it is medically possible that Mr. Ramotowski "subsequent to the accident indicating that he had difficulty walking," had some sort of back pain that can cause a previously asymptomatic degenerative condition in his lower extremities, such as his knee, to become symptomatic. He testified that if it is, in fact, the case that the petitioner is walking around limping or doing things that, in fact, might cause a referred problem in his ankle and his knee just from the mere fact that he is not ambulating properly. (Rx. 6, pp. 32-33)

Dr. Cole charges $1,200.00 for his Section 12 exams and $2,000 minimum for a deposition and does about three or four per month. (Rx. 6, pp. 34-35)

Dr. Cole testified that when he examined the petitioner, the petitioner did not voice specific complaints of tenderness on the inner side of his knee with meniscus-type symptoms, but said that his knee hurt all over. The petitioner did complain of medial joint leg pain that was very nonspecific. (Rx. 6, pp. 41, 44) The posterior horn of the medial meniscus, especially in association with osteoarthritis, is usually a degenerative tear, not an acute tear. (Rx. 6, p 45) Typically, a traumatic or acute tear is associated with "a relatively abrupt knee effusion, in other words, the knee swells up and call attention to it." (Rx. 6, p. 46) When Dr. Cole examined the

petitioner, he did not document swelling, so if he did not document it, it was not here. Dr. Cole did not know if Dr. Nowak ever examined the petitioner's knee. (Rx. 6, pp. 46-47)

On redirect examination, Dr. Cole testified that he is not a back specialist and does not feel comfortable opining about the petitioner's back condition. He also testified that in the general population over 50, a meniscal tear occurs in association with osteoarthritis 70% of the time. Dr. Cole testified that the records in totality support his opinion - - that is, before and after the knee appeared in the record. With regard to his testimony that the petitioner self-reported a sudden onset of left knee pain, Dr. Cole was referring to the intake form that Mr. Ramotowski completed on June 18, 2012 as part of his examination. Dr. Cole testified that medical studies establish that there is a significant correlation of excess BMI with radiologic findings of meniscal pathology and osteoarthritis. (Rx. 6, pp. 54-60)

On recross examination, Dr. Cole testified with regard to the significance of the medical studies. So, although 70% of the people that are over 50 and have a certain BMI have meniscus tears, some will be symptomatic and some will not, but there will be a higher frequency of MRI findings than there will be the frequency of symptoms of those who have symptoms. Many people are asymptomatic that have certain physiological characteristics of their knee. Limping might create referred pain in other parts of the body including the knee. It is possible that limping or difficulty ambulating can take a previously asymptomatic condition and then make it symptomatic. Dr. Cole made the determination that the petitioner's left knee pain was a spontaneous manifestation based upon the timeline of Dr. Nowak's records, the status of degeneration of the knee and his obesity. At that point, it is very difficult to say which one caused or was the inciting factor. It could be a 50/50 percent chance. (Rx. 6, pp. 62-65)

Initial/Early Medical Treatment:

Following the lifting incident of July 14, 2011, the petitioner first treated with his family doctor, Waldemar Nowak, M.D., on July 18, 2011. On that date, Dr. Nowak found, *inter alia*, the following:

C.C./H.P.I.: According to the pt.— developed severe low back pain with radiation to the leg on July 14, 2011 after lifting and pushing heavy – "roller" – at work – pain progressively worse since that time – problem walking, problem bending and sitting due to pain.

W.: 318 lbs/kg

ABDOMEN: Obese
EXTREMITY: Leg raising (+) 30° both legs
*JOINTS: WNL**
NEURO: knee reflexes ↓

Dr. Nowak assessed the petitioner with low back pain, leg pain and W.C. injury (back). He took the petitioner off work for one week, ordered x-rays of the lumbar spine, prescribed medication and a physical therapy evaluation and advised the petitioner to return to the clinic in a week. (Px. 1)

The petitioner returned to Dr. Nowak on July 25, 2011. On that date, Dr. Nowak found, *inter alia*, the following:

C.C./H.P.I.: Still low back pain c radiation to both legs – worse since last visit – still problems walking due to pain
EXTREMITY: leg elevation (+) 25°
JOINTS: Ø
NEURO: knee reflexes ↓

Dr. Nowak assessed the petitioner with a low back injury, low back pain c̄ legs pain. He took the petitioner off work for four weeks, ordered an MRI of the lumbar spine without contrast, prescribed medication and advised him to continue with physical therapy and to return to the clinic in a week. (Px. 1)

In a report dated July 25, 2011, Djordje Boskov, M.D., offered the following impression of the petitioner's lumbar spine x-rays and compared them with x-rays taken on October 21, 2010:

> *No acute fracture or dislocation, mild degenerative changes as detailed above, no significant interval differences are seen.* (Px. 1)

In a report dated July 29, 2011, Djordje Boskov, M.D., offered the following impression of the petitioner's lumbar spine MRI, without contrast:

1. *Diffuse lower lumbar spondylosis with multilevel annular disc bulging and hypertrophy of posterior elements as detailed above, most prominent at L4-5*

2. *At L4-5, there is a 3.5 mm diffuse disc bulging and hypertrophy of posterior elements causing mild/moderate spinal and neural foraminal stenosis.* (Px. 1)

The petitioner returned to Dr. Nowak on August 18, 2011. On that date, Dr. Nowak found, *inter alia*, the following:

C.C./H.P.I.: *Still low back pain with radiation to L leg with L leg numbness – pain aggravated by walking and bending*
EXTREMITY: *leg raising (L) (+) 30° , (R) (+) 40°*
JOINTS: *WNL*
NEURO: *WNL*
MRI – disc bulging – L4-5 disc bulging with spinal stenosis.

Dr. Nowak assessed the petitioner with a low back injury, low back pain and leg pain/numbness. He took the petitioner off work for four more weeks, ordered an MRI, prescribed medication and p.t. treatment and advised him to return to the clinic in 4 weeks. (Px. 1)

The petitioner returned to Dr. Nowak on September 7, 2011. On that date, Dr. Nowak found, *inter alia*, the following:

C.C./H.P.I.: ** No improvement -- worse low back pain (9 of 10), upper back pain (6 of 10), L leg pain with numbness*
EXTREMITY: *(L) leg raising (+) 30°*
JOINTS: --
NEURO: --

Dr. Nowak assessed the petitioner with low back pain, L leg pain, upper back pain and L-radiculopathy. He prescribed medication, ordered physical therapy evaluation and treatment and advised him to return to the clinic in 2 weeks. (Px. 1)

The petitioner returned to Dr. Nowak on September 19, 2011. On that date, Dr. Nowak found, *inter alia*, the following:

C.C./H.P.I.: *Still low back pain with radiation c radiation to (L) leg – P. T. not done due to ins. problem*
EXTREMITY:

JOINTS: Leg radiating ⊕ (L) 30° R 50°
NEURO: ~

Dr. Nowak assessed the petitioner with low back pain, (L) leg pain/numbness, and L-radiculopathy. He continued to prescribe medication, ordered physical therapy, took him off work until 10/15/11 and advised him to return to the clinic in 1 month. (Px. 1)

On October 10, 2011, at the request of the respondent and pursuant to Section 12 of the Act, the petitioner presented to Edward Goldberg, M.D., for an examination. (Rx. 5, Dep. Ex. 2)

On October 14, 2011, the petitioner underwent a physical therapy evaluation at Advanced Rehabilitation Services. The list of "PROBLEMS" are as follows: (1) LOWER BACK PAIN WITH RADIATING TO BOTH LE, (2) DECREASED MUSCLE STRENGTH OF TRUNK AND BOTH LE, (3) DECREASED AROM OF TRUNK AND BOTH LE, (4) INCREASED MM TONE, AND (5) DIFFICULTY WALKING AND PERFORMING ADL'S. The "GAIT, POSTURE" section states: ANTALGIC, DECREASED LUMBAR LORDOSIS. The petitioner complained of constant severe pain of the low back rated 9/10 during active movement, 7/10 at night and 7/10 at rest. The radiating pain was more to the left than the right. He has been complaining of pain since an accident at work. The petitioner stated that symptoms get worse after prolonged walking or standing. The petitioner reported difficulties with bending, turning, driving a car, walking, sleeping and performing ADLs. (Px. 1)

The petitioner returned to Dr. Nowak on October 14, 2011. On that date, Dr. Nowak found, *inter alia*, the following:

C.C./H.P.I.: Still low back pain, upper back pain
- Initial study done
- Results pending
EXTREMITY: No new changes
JOINTS:
NEURO:

Dr. Nowak assessed the petitioner with low back pain and upper back pain. He ordered the petitioner to continue with physical therapy, took him off work until 11/30/11 and advised him to return to the clinic in one month. (Px. 1)

The petitioner returned to Dr. Nowak on November 2, 2011. On that date, Dr. Nowak found, *inter alia*, the following:

*C.C./H.P.I.: * Still low back pain ~*

Dr. Goldberg consultation noted

EXTREMITY: No new changes
JOINTS: No new changes
NEURO: No new changes

Dr. Nowak assessed the petitioner with low back pain and L – Radiculopathy. He ordered the petitioner to continue with physical therapy and see Dr. Yapor on neuro for a surgical consultation. (Px. 1)

On November 29, 2011, neurosurgeon Wesley Y. Yapor, M.D., examined the petitioner. In his report, Dr. Yapor wrote the following:

Re: Waldemar Ramotowski

*Mr. Ramotowski is a 51-year-old male who works for a contractor and does heavy labor. The patient states that he was in perfect health until July 14, 2011, when he sustained a work related injury. He had to manually pick up a heavy object and lift it from the street on to the truck. He felt instant back pain and reported this to his supervisor. The patient was asked to work for a period of time and was sent home after continued complaints of back pain. He has been complaining of neck pain, which is associated with discomfort and numbness in the right upper extremity. His low back pain is associated with radicular symptoms radiating down the lateral and anterior aspect of the left thigh, as well as pain within the knee joint with swelling just below the kneecap. He has been getting physical therapy with limited improvement. He has been placed on Flexeril, as well as analgesics. He has not had any epidural steroid injections or surgery to date. He has had seven chiropractic treatments by Dr. Zoboski, which was required secondary to what sounds like a work related injury four months prior to treatments. At that time, the patient was lifting a four hundred pound manhole and had instant back pain. ****

Physical examination reveals full range of motion of the cervical and lumbar spine in all directions. He is tender in the lumbar area. The patient states that he has decreased sensation in the right upper extremity over the biceps region, going down into the forearm. The hand seems to be equal. The left lower extremity along the anterolateral

thigh has decreased sensation. Straight leg raise is positive on the left to approximately forty-five degrees. He is tender over the knee. There is some swelling below the knee-cap in the left knee area. Reflexes are normal throughout. No pathological reflexes were noted. Motor strength appears to be intact. **** (Rx.14)

Dr. Yapor reviewed the MRI of the lumbar spine and believed that there is a central disc herniation at the L4-L5 level with some compression of the thecal sac. As far as the other discs, he believed that there is only minimal disc disease elsewhere. Dr. Yapor then ordered an MRI of the cervical spine as well as an MRI of the left knee. (Rx. 14)

The petitioner returned to Dr. Nowak on November 30, 2011. On that date, Dr. Nowak found, *inter alia*, the following:

C.C./H.P.I.: * *Sent for MRI of (L) knee and MRI of C-spine*
* *Still unable to work*
* *Still back pain - knee pain*

HEENT: *Neck - RROM*

EXTREMITY: *Now new change*
JOINTS: *Now new change*
NEURO:

Dr. Nowak assessed the petitioner with back pain, neck pain and knee pain. He advised the petitioner to continue with physical therapy, prescribed medication instructed him to return to the clinic in four weeks. (Px. 1)

On December 7, 2011, MR images, without contrast, were taken of the petitioner's left knee. Gabrielle Bosley, M.D., offered the following impression of such images:

1. *Infrapatellar bursitis*
2. *Tear of the posterior horn of the medical meniscus*
3. *A tear of the anterior horn of the lateral meniscus with adjacent para meniscal cyst versus a synovial cyst*
4. *Lateral subluxation of the patella*
5. *Grade I sprain of the medial and lateral collateral ligament*
6. *A ganglion cyst adjacent to head of the fibula*

7. *Mixed signal in the pre-patellar bursa and in the cyst adjacent to the head of the fibula raises the question of possible hemorrhage or atypical synovitis*

On December 7, 2011, MR images, without contrast, were taken of the petitioner's cervical spine. Gabrielle Bosley, M.D., offered the following impression of such images:

> Straightening of the cervical spine. This finding is sometimes associated with muscle spasm. Mild left neural femoral (sic) stenosis at C4-C5 and C5-C6.

On January 10, 2012, neurosurgeon Wesley Y. Yapor, M.D., examined the petitioner in follow-up. In his report, Dr. Yapor wrote the following:

Re: Waldemar Ramotowski

> *Mr. Ramotowski is seen on follow-up and has similar complaints, which are mainly his neck, low back, and left leg. The leg specifically is in and around the knee area. The MRI of the cervical spine showed mild degenerative change but no disc herniation and some mild strengthening of the cervical spine. This could be positional or secondary to muscle spasm. I see no surgical lesion in the cervical area. The MRI of the left knee shows significant pathology in the knee with infrapatellar bursitis, a tear of the posterior horn of the medical meniscus, a tear of the anterior horn of the lateral meniscus with adjacent parameniscal cyst versus a synovial cyst, lateral subluxation of the patella, a grade I sprain of the medial and lateral collateral ligament, a ganglion cyst adjacent to the head of the fibula, and mixed signal in the pre-patellar bursa and in the cyst adjacent to the head of the fibula. This raises the question of possible hemorrhage or a typical synovitis.*
>
> *The patient was advised that I did not want to order any therapy for him at this time. Since I do not want to cause any further damage to the left knee, I would like to have him see an orthopedic surgeon. He was advised to contact Dr. Nowak for a referral to an orthopedic surgeon near his home. Mr. Ramotowski is to return once the knee pathology has been treated and he is cleared for physical therapy for his lumbar and cervical spine.* (Rx. 14)

The petitioner returned to Dr. Nowak on January 11, 2012. On that date, Dr. Nowak found, *inter alia*, the following:

C.C./H.P.I.: (L) *leg (L.E.) pain mostly in* (L) *knee,*
Still low back pain,
Neck pain c (R) *shoulder pain*
HEENT: *Neck - RROM*
EXTREMITY: (L) *knee edema, RROM*
JOINTS: *?*
NEURO: *--*

Dr. Nowak assessed the petitioner with knee pain, (L) leg pain, low back pain and neck/shoulder pain. He wrote that the petitioner needs an ortho. eval. of his (L) knee – Dr. Favabven? (Px. 1)

Summary of Subsequent Medical Treatment:

1/26/12	F/u with Dr. Nowak Sleep problem due to back/knee pain
2/29/12	F/u Dr. Nowak Still back pain
4/4/12	F/u with Dr. Nowak Still back pain and knee pain
5/2/12	F/u with Dr. Nowak Low, pain, neck pain, left knee pain, right shoulder pain On medication
5/10/12	F/u with Dr. Nowak
5/14/12	F/u with Dr. Nowak C/o low back and leg pain Plan continued PT
5/17/12- 6/6/12	Physical and Aquatic Therapy for lumbar pain
6/13/12	**Initial visit with Dr. Malgorzata Szyfer** Diagnosis: Lumbar radiculopathy, left knee pain, osteoarthritis, neck pain, thoracic pain, paresthesias in both hands, insomnia, Plan: Off work and medications
6/18/12	**Section 12 Examination by Dr. Brian Cole**

7/6/12	F/u with Dr. Szyfer Awaiting IME to be scheduled
9/13/12	F/u with Dr. Szyfer Recommended PT
10/23/12	F/u with Dr. Szyfer Continue PT and medications
11/20/12	F/u with Dr. Szyfer Referral for orthopedic consultation Awaiting IME scheduled for 11/23/12
11/28/12	F/u with Dr. Nowak C/o low back pain L-radiculopathy Knee pain
11/28/12	**Section 12 Examination by Dr. Edward Goldberg** No further treatment required for lumbar spine
12/3/12	F/u with Dr. Nowak Still low back, leg and knee pain Prescribed medication
12/20/12	F/u with Dr. Nowak Still low back, leg and knee pain Prescribed medication
1/3/13	F/u with Dr. Yapor C/o pain both knees and increased pain in back Prescribed f/u MRIs of spine and knees
1/4/13	**Initial visit with Dr. Mark Sokolowski (referred by Dr. Szyfer)** Reviewed Section 12 report Plan: Proceed with FCE
2/6/13	**Initial visit with Dr. Ronald Silver (referred by Dr. Sokolowski)** Plan: left knee replacement Prescribed medications
2/8/13	F/u with Dr. Sokolowski Plan: proceed with left knee surgery through Dr. Silver
2/15/13	F/u with Dr. Sokolowski Given Medrol Dosepak Recommends: ESI

3/6/13	F/u with Dr. Silver Prescribed narcotic pain pills X-rays demonstrate complete loss of articular cartilage
3/21/13	F/u with Dr. Sokolowski Wait approval of left knee surgery, proceed with ESI and prescribed meds
4/3/13	F/u with Dr. Silver Surgery pending
4/8/13	**Initial visit with Dr. Jay Kiokemeister (Dr. Sokolowski referral for ESI)** Diagnosis: lumbar radiculopathy
4/15/13	F/u with Dr. Kiokemeister ESI at L4-L5
4/18/13	F/u with Dr. Sokolowski Received ESI
4/29/13	F/u with Dr. Kiokemeister Outpatient Note
5/1/13	F/u with Dr. Silver
5/6/13	F/u with Dr. Sokolowski
5/20/13	F/u with Dr. Sokolowski Lumbar decompression surgery possibility
6/5/13	F/u with Dr. Silver Patient can barely walk
6/24/13	F/u with Dr. Sokolowski
7/10/13	F/u with Dr. Silver Surgery pending
8/7/13	F/u with Dr. Silver Pain has been resistant to knee brace, anti-inflammatory and steroid injections
8/8/13	F/u with Dr. Sokolowski Still awaiting left knee surgery approval
9/11/13	F/u with Dr. Silver
10/1/13	F/u with Dr. Sokolowski Knee surgery is likely to diminish lumbar spine pain

10/9/13	F/u with Dr. Silver Still waiting on left knee replacement authorization
11/13/13	F/u with Dr. Silver
12/02/13	F/u with Dr. Sokolowski Requires left knee surgery
12/18/13	F/u with Dr. Silver Severe loss of cartilage in tibiofemoral Lacking surgery client will be permanently disabled
1/22/14	F/u with Dr. Silver Waiting for knee replacement authorization
2/4/14	Diagnostic tests at Edgebrook Radiology MRI lumbar spine – L3-L4, L4-L5 posterior disk herniation L5-S1 subligamentous broad-based posterior disk herniation MRI cervical spine – C4-C5, 2-3mm posterior central broad-based disk protrusion/herniation C5-C6, 3-4mm broad based posterior slightly left sided disk herniation C6-C7, 3-4mm posterior and left sided disk herniation MRI left knee – Medial meniscal tear involving anterior horn, midbody and posterior horn. Joint effusion. MRI right knee – Medial meniscal tear involving anterior horn, midbody and posterior horn. Small joint effusion with a small Baker's cyst in the popliteal fossa
2/19/14	F/u with Dr. Silver
3/10/14	F/u with Dr. Sokolowski Continues to require left knee surgery Knee surgery can diminish lumbar spine pain Prescribed Hydrocodone and Dendracin
3/26/14	F/u with Dr. Silver Plan is for knee replacement Prescribed Meloxicam for inflammation Protonix for gastrointestinal protection Hydrocodone for pain Ultram for lower levels of discomfort Terocin cream for pain relief
4/30/14	F/u with Dr. Silver Left knee surgery pending
5/12/14	F/u with Dr. Sokolowski Continues to require left knee surgery

Knee surgery can diminish lumbar spine pain
Prescribed Hydrocodone and Dendracin

6/11/14 F/u with Dr. Silver

7/18/14 F/u with Dr. Silver

7/23/14 F/u with Dr. Sokolowski
Significant knee pain bilaterally
Left knee effusion and joint line tenderness to palpation
Right knee meniscal tear
Needs knee surgery and lumbar spine surgery
Refilled Hydrocodone and Dendracin

8/29/14 F/u with Dr. Silver
Still awaiting left total knee replacement
Continues to ambulate for short distances with a cane
Lacking knee replacement will be permanently disabled

10/3/14 F/u with Dr. Silver

10/10/14 F/u with Dr. Mark Sokolowski
C/o neck pain, lumbar pain with radiation to bilateral buttocks
Left knee pain
Left knee effusion and joint line tenderness to palpation
Plan: knee surgery/ lumbar spine surgery

10/22/14 F/u with Dr. Silver
Permanent severe exacerbation and acceleration of pre-existing asymptomatic degenerative change of left knee due to work injury
Can only walk short distances with a cane and brace
Exhausted conservative care

11/7/14 F/u with Dr. Silver

12/12/14 F/u with Dr. Silver
Next appointment pending surgery

Surveillance Reports and Videos

The respondent offered, and the Arbitrator admitted into evidence, Respondent's Exhibits 9, 10, 11, 12, and 19, which are the reports from the surveillance conducted of the petitioner on multiple dates between October 19, 2011 and December 18, 2013. The videos of such surveillance were admitted as Respondent's Exhibits 17, 18, 20, 21, 22, 23, and 24.

During the times of surveillance, the petitioner is shown without a cane performing activities that include lifting, shopping, standing, conversing while standing and walking. The petitioner is shown meeting colleagues at what appears to be a job site where he lifts windows.

The Arbitrator notes that the only respondent witness to comment on the surveillance video was Edward Goldberg, M.D.

The Arbitrator further notes that Dr. Goldberg was provided with only video from September 11, 12 and 13, 2012. Dr. Goldberg testified that the video is of the "lay observation" type and does not require a medical opinion to make a determination. (Rx. 5, p. 37)

Dr. Goldberg opined that the petitioner appeared to be able to flex his lumbar spine by looking into the hood of a minivan. The petitioner exhibited fluid motion with the degree of bending. (Rx. 5, p. 38)

Dr. Goldberg also concluded that the petitioner did not display any pain behavior because the doctor did not see him moving without a fluid motion. Moreover, the doctor did not see the petitioner grimacing or showing some expression that he was in pain. (Rx. 5, p. 39)

Dr. Goldberg testified that the September 11, 2012 video was not in itself sufficient to cause him to form the opinion that Mr. Ramotowski could return to full-duty work and was at maximum medical improvement. There were examination findings as well. (Rx. 5, p. 39)

Dr. Goldberg testified that the September 12th video was not of any medical significance other than that "he appeared in no distress." As for the September 13th video, the witness did not find it of any significance. (Rx. 5, p. 42)

Dr. Sokolowski testified that if he observed the petitioner walking with a normal gait and getting in and out of a car in 2011, 2012, or 2013, that would not change his opinion as to his medical condition in 2015. (Tr. of 1/13/2015, p. 30)

Dr. Silver testified that if he saw surveillance video that depicted the petitioner walking slowly, that would not change his opinion with regard to the petitioner's condition or need for a total knee replacement. If he saw surveillance video that showed the petitioner standing outside and getting in and out of a car, such video would not have any effect on the opinions he rendered during the deposition. (Px. 12, pp. 36-37) On cross-examination, Dr. Silver testified that there is no distance that he does not believe the petitioner can walk given his condition with or without assistance of medication or a cane. He explained that the petitioner's actions would be mitigated by his toughness. (Px. 12, p. 67)

CONCLUSIONS OF LAW

In support of his conclusion with regard to issue (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?," the Arbitrator finds as follows:

The parties have stipulated to the issue of "accident" with respect to the petitioner's low back/lumbar spine injury.

With regard to an alleged accidental injury to the petitioner's left knee on July 14, 2011, Waldemar Ramotowski testified to the following:

> *We were putting it [the roller] down. And at that time, I felt pain, terrible pain in my back and it felt like somebody was putting a knife, and I had this crunch noise in my knee and my whole leg started to hurt at that time. For a moment, I just stood there and I do not know how long. Eventually I started slowly working.*

Four days after this incident, the petitioner sought treatment with his primary care physician, Waldemar Nowak, M.D. Dr. Nowak speaks English and Polish. In the current complaints/history of present injury section of his July 18, 2011 chart notes, Dr. Nowak wrote the following:

> *According to the pt. – developed severe low back pain with radiation to the leg on July 14, 2011 after lifting and pushing heavy – "roller" – at work – pain progressively worse since that time – problem walking, problem bending and sitting due to pain.*

Dr. Nowak, at that time, recorded the petitioner's weight at 318 pounds, found the petitioner to be obese, found his straight leg raising test to be positive bilaterally at 30° and found his joints to be within normal limits. Dr. Nowak's neurological examination revealed that the petitioner's knee reflexes were diminished.

Both Dr. Zoboski and Dr. Cole found the petitioner to be 5'9" tall.

Nowhere in his July 18, 2011 chart notes does Dr. Nowak mention an injury to either knee, swelling in the petitioner's leg or a report by the petitioner of a crunch sound or sensation in his left knee when he lowered the roller.

The Arbitrator points out that Dr. Nowak is a Medical Doctor who speaks Polish and English. The Arbitrator draws the reasonable inference that Dr. Nowak knows and can translate the difference between a leg and a knee.

It was not until November 29, 2011, or 4-1/2 months post-accident, that there were documented complaints by the petitioner of left knee pain. On November 29, 2011, Dr. Yapor, a neurosurgeon, examined the petitioner.

Dr. Silver, the petitioner's treating orthopedic surgeon, diagnosed the petitioner with damaged cartilage of the left knee due to the July 14, 2011 accident. Dr. Silver based his opinion that the petitioner damaged the cartilage in his left knee on that day on the following: the lack of left knee symptoms prior to the July 14, 2011, the mechanism of injury (bending down), which is an appropriate way to crack cartilage, his clinical examination findings and the MRI scan that verified his clinical findings.

Dr. Silver testified that a patient with a knee problem may complain of pain going down their shin and up their thigh.

Dr. Silver opined that back pain can alter one's gait so that one ends up stressing the knee more, which can contribute to knee pain.

With regard to his opinions on the petitioner's body habitus and the minimum weight of an individual who has a greater chance of developing arthritis, the Arbitrator finds that Dr. Silver is not persuasive. On June 20, 2011, the petitioner's primary care physician, Dr. Nowak, assessed the petitioner with "morbid obesity." (Rx. 14) Moreover, Dr. Silver would "draw the line" at only a minimum of 350 pounds for those individuals who have a greater chance of developing arthritis. It appears that the height of an individual is not a factor in Dr. Silver's calculus. On July 18, 2011, the petitioner was 5'9" and 318 pounds. Dr. Cole, however, credibly testified that there is a significant correlation between excess BMI and radiologic findings of meniscal pathology and osteoarthritis.

Dr. Cole, the respondent's examining orthopedic surgeon, offered the following impression of the petitioner's condition: "left knee arthritis, nonwork-related and low back pain." The basis of Dr. Cole's opinion is as follows: The length of time to accumulate osteoarthritis is significant, those were chronic changes on his X-ray, and there was no immediate evidence of pain right after the injury in the left knee, but rather it seemed to be low back with radiation. So, it seems like this was an underlying condition that maybe became symptomatic during the process, but I don't think it was caused or even aggravated at least based upon the timeline provided.

Dr. Cole testified that if the petitioner had experienced cartilage damage to his left knee on July 14, 2011, he would have expected to see focal knee complaints immediately, or at least early on.

On recross examination, Dr. Cole then testified to the following:

Q: We've also established that limping after an accident whether it's due to some sort of compressive pathology in the lumbar spine, some sort of other problem that that can create referred pain in other parts of the body including the knee?

A: Yes, it might occur.

Q: And such limping or difficulty ambulating, in fact, can take a previously asymptomatic degenerative condition and then make it symptomatic, right?

A: It's possible.

Q: This, in fact, would be an aggravation of that pre-existing degenerative condition, right?

A: If you describe that fact pattern. The challenge is you just don't know if it's a spontaneous manifestation. As time goes on, you don't know which is which.

Q: You've made a determination that, in fact, it was a spontaneous manifestation based upon the timeline of Dr. Nowak's records?

A: And the status of degeneration of his knee and his obesity. At that point I think it's very difficult to tell which one caused or was the inciting factor.

Q: And, in fact, it becomes extremely difficult to know, and that probably is about a 50/50 percent chance?

A: Could be.

Dr. Sokolowski, the petitioner's treating physician for his low back injury, offered the following opinion on direct examination:

Q: Could you explain to the Arbitrator, please, the relationship between an abnormal gait caused by a back injury and its effect or referred pain it could have on a person's alternative joints such as his knee.

A: So if there is neural impingement especially at the L4-L5 level, the L5 nerve "intervates" (phonetic) among other muscles, the gluteus medius muscle which is an abductor of the hip. And so patients with L5 radiculopathy will sometimes have as their only manifestation of that

radiculopathy a limping gait pattern on the affected side because the gluteus medius is weak. So it stands to reason that if you are limping for a protracted period of time, the other extremities and even joints on the same extremity are adversely affected by virtue of the abnormal gait pattern and abnormal mechanics to which those joints above and below the affected region are subjected.

On cross-examination, Dr. Sokolowski testified that on approximately ten occasions, i.e., each time he saw the petitioner, the petitioner exhibited a gait that was altered on the left.

After the July 14, 2011 accident, Dr. Nowak noted several times that the petitioner had a problem with walking, which would suggest that the petitioner did not walk as he normally walked. On October 14, 2011, during the physical therapy evaluation, the therapist wrote, in the "GAIT, POSTURE" section, the following: ANTALGIC, DECREASED LUMBAR LORDOSIS. The initial surveillance video of October 19, 2011 at 12:29 p.m., the video of October 22, 2011 at 12:19 p.m. (Rx. 17), and the video of December 21, 2012 at 12:25 p.m. (Rx. 21) display, the petitioner putting more weight on his left leg and knee.

The Arbitrator notes that on November 29, 2011, Dr. Yapor diagnosed the petitioner with a central disc herniation at L4-5 with some compression of the thecal sac.

The Arbitrator also notes that throughout the course of the entire surveillance (Respondent's Exhibits 17, 18, 20, 21, 22, 23, and 24), the petitioner, not infrequently, appeared to look directly at the videographer. So, to the extent that the petitioner displayed a true and accurate representation of his gait pattern, he exhibited weight-shifting to his left leg on these occasions.

Given the opinions of Dr. Sokolowski, Dr. Silver and, to some extent, Dr. Cole, as well as the records of Dr. Nowak and Dr. Yapor, the physical therapy evaluation report of October 14, 2011, and the surveillance video, the Arbitrator finds, by a mere preponderance of the evidence, that the petitioner sustained an aggravation of the pre-existing, degenerative condition of his left knee as a result of the change in his gait pattern that resulted from the accidental injury to his low back on July 14, 2011. Therefore, he finds that the petitioner sustained an accident to his left knee that arose out of and in the course of his employment by the respondent. There is no documentary evidence that the petitioner had a problem walking or walked with an antalgic gait before July 14, 2011.

Every natural consequence that flows from a compensable accident is also compensable unless caused by an independent intervening accident that breaks the chain of

causation between a work-related injury and an ensuing disability or injury. Teska v. Indus. Comm'n, 266 Ill. App. 3d 740, 742 (1994).

In support of his conclusion with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?," the Arbitrator finds as follows:

With regard to the petitioner's low back condition, the Arbitrator notes that the medical records from July 18, 2011 (the initial date of treatment) onward reflect low back pain with radiating symptoms to the lower extremities, left worse than right. Moveover, when Wesley Y. Yapor, M.D., a neurosurgeon, examined the petitioner on November 29, 2011, he found, *inter alia*, that the straight leg raising test was positive on the left to approximately 45°. Dr. Yapor also reviewed the MRI of the petitioner's lumbar spine and interpreted the images as showing a central disc herniation at the L4-L5 level with some compression of the thecal sac. (Px. 1, Rx. 4)

The petitioner testified that in 2010, he injured his back when he was working on a sewer in a parking lot. When he and his co-workers were lifting a cast iron piece, he felt pain in his back. He could say that he "saw stars" due to the pain. He thought that he had overstretched his muscles at that time. Following that back injury, the petitioner went to his family doctor who referred him to Dr. Zoboski for massages. On his sixth or seventh visit to Dr. Zaboski, the petitioner testified, he felt good enough to go back to work and returned to full-duty work. (Tr. 80-81)

X-rays of the petitioner's lumbar spine were taken on October 21, 2010. Radiologist Eugene Pai, M.D., offered the following impression of such images: "Degenerative disc disease." (Px. 16)

In Dr. Robert Zoboski's December 17, 2010 Patient Report, he noted that the petitioner's lumbar spine symptoms have resolved. Upon examination, Dr. Zoboski found the petitioner's active range of motion of the lumbar spine to be essentially full and without pain at the extremes. Neurologically, he found the petitioner to be intact without any focal deficits. Dr. Zoboski declared the petitioner to be at maximum medical improvement and discharged him from his care. (Px. 16)

With regard to the petitioner's low back condition, the Arbitrator finds the opinions of Dr. Sokolowski to be more persuasive than those of Dr. Goldberg.

The Arbitrator finds that the Petitioner has sustained this burden with regard to both his left knee and low back.

Based on the foregoing, the Arbitrator finds that the petitioner's current condition of ill-being of his low back is causally related to the accident of July 14, 2011.

Based on the opinions of Dr. Silver, Dr. Sokolowski and, to some extent, Dr. Cole, as well as on the treating records and the surveillance videos of October 19, 2011 and October 22, 2011 (Rx. 17), the Arbitrator finds that the petitioner's current condition of ill-being of his left leg is causally related to the accident of July 14, 2011.

In support of his conclusions with regard to issues (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?,"and (O) Reimbursement of out-of-pocket expenses, the Arbitrator finds as follows:

The Arbitrator finds that the medical services rendered by the petitioner's treating physicians in connection with his July 14, 2011 work-related injury have been reasonable, necessary and related. Accordingly, pursuant to Section 8(a), the Arbitrator awards the petitioner the total of the unpaid medical bills in the amount of $86,525.63*, subject to Section 8.2 of the Act.

The Arbitrator further finds that the respondent shall reimburse the petitioner out-of-pocket expenses in the amount of $480.00, subject to Section 8.2 of the Act. The petitioner paid Dr. Nowak $80.00 per visit for 6 office visits (DOS 7/18/11, 7/25/11, 8/18/11, 9/7/11, 9/19/11 and 10/14/11).

*This yet-to-be-fee-scheduled total is broken down as follows: Dr. Nowak, $240.00 (Px.1), Dr. Szyfer, $1,040.00 (Px.2), Dr. Yapor, $160.00 (Px. 3), Dr. Silver, $3,622.00 (Px. 5), Dr. Sokolowski, $6,530.00 (Px. 4), Dr. Kiokemeister, $6,783.53 (Px. 6), Edgebrook Radiology, $6,414.00 (Px. 7), Rx Development Pharmaceutical, $43,095.97 (Px. 9) and Prescription Partners, $18,640.10 (Px. 8)

In support of his conclusion with regard to issue (K) "Is Petitioner entitled to any prospective medical care?," the Arbitrator finds as follows:

The Arbitrator finds that the petitioner first became symptomatic and has remained symptomatic since his work accident. The Arbitrator further finds, by a preponderance of the

medical evidence, that the petitioner is currently suffering from lumbar radiculopathy caused by a herniated disc at L4-5 and a painful, destabilized left knee that requires a replacement. The Arbitrator bases this finding on the treating medical records and the petitioner's testimony.

The Arbitrator finds that the lumbar surgery as prescribed by Dr. Sokolowski and the total knee replacement surgery as recommended by Dr. Silver are reasonable and necessary to relieve the petitioner from symptoms that are causally related to the work accident.

Therefore, the Arbitrator orders the respondent to authorize and pay for these two surgeries, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

In support of his conclusion with regard to issue (L) "What temporary benefits are in dispute? TTD," the Arbitrator finds as follows:

The Illinois Supreme Court holds that "when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.*, whether the claimant has reached maximum medical improvement. Interstate Scaffolding v. Illinois Workers' Compensation Comm'n, 236 Ill. 2d 132 (2010). Moreover, a claimant will not be eligible for TTD benefits during the periods in which he has earned wages.

The respondent terminated TTD benefits on December 11, 2012 after Dr. Goldberg's examination. However, the Arbitrator finds the opinions of Dr. Sokolowski to be more persuasive than those of Dr. Goldberg.

Based on the testimony of the petitioner and his medical treatment records, the Arbitrator finds that Mr. Ramotowski's condition of ill-being that resulted from his accident of July 14, 2011 has not yet stabilized, *i.e.*, he has not reached maximum medical improvement.

The only questionable physical activity depicted on the video is from October 2011 and is now over three year old. In October 2011, the petitioner gathered with his friends from the neighborhood, which the petitioner referred to as his "colleagues," as well as their sons, consumed beer and engaged in physical activity in a garage. During a two-minute period, the petitioner is shown removing a window from its sill. The window was described as weighing 25-30 pounds.

There is no evidence to indicate that the petitioner earned any wages subsequent to July 14, 2011.

The unrebutted testimony is that the work of an operating engineer at AARP is "very heavy" work and that required the use of a jackhammer, a pneumatic hammer, sledgehammer, pick, shovel and hand roller and that also required rolling asphalt with the roller, fixing sewers and lifting manhole covers.

The Arbitrator further finds that the petitioner was temporarily totally disabled and removed from work from July 15, 2011 through January 15, 2015. Therefore, he finds that the petitioner is entitled to TTD benefits during such period. The respondent shall be give a credit for TTD benefits previously paid.

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)
MCHENRY		☒ PTD/Fatal denied
	☒ Modify down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Norma Maciel,

Petitioner,

vs. NO: 10 WC 38998

Heritage Woods,

Respondent,

16IWCC0432

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 both prospective and incurred, causal connection, temporary total disability, permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's decision and finds that temporary total disability should be terminated as of March 1, 2011 and that the Petitioner's condition was at maximum medical improvement as of that date. The Commission also finds that not all medical bills after that date were reasonable or necessary. The Commission further finds that Petitioner is entitled to a 20% loss of use to the person as a whole as a result of this injury.

The Petitioner allegedly injured her low back vacuuming the common area at work. There was popcorn underneath the sofa and she had to lift the sofa chair to get at it. She bent a little bit, twisted, and felt the pain in her low back. She claimed she had very sharp pain in her lower back and could not move. (Transcript Pgs. 15-16)

She sought treatment at the Centegra Occupational Center. She saw them 3 times the last being September 16, 2001. Petitioner called into Centegra on September 21, 2010 and advised them that she was going to see her own doctor. On September 16, 2010, the pain was radiating

into both the left and right buttocks but not her legs. The pain was also radiating into the thoracic area. (Petitioner Exhibit 1)

Petitioner chose to see Dr. Ashar Syed, an internal medicine doctor. He found that she complained of back pain going into both legs. She claimed she was not doing well and asked the doctor to provide her with an excuse from work. She saw Syed again on October 7, October 14, and October 21, 2010. The doctor noted no changes in her complaints but did indicate that Petitioner indicated that she needed more time off work. (Petitioner Exhibit 2)

Dr. Syed referred the Petitioner to Dr. Nasaruddin who specializes in pain medicine. He prescribed a trial of epidurals on October 28, 2010. (Petitioner Exhibit 4)

Respondent had the Petitioner evaluated by Dr. Jay Levin on November 8, 2010. He took a history from Petitioner that consisted of non-stop pain in her back, which was getting worse. The pain went up into her shoulder blades. She indicated most of her pain was on the left side. She could not mention specific toes that were numb but instead replied that the numbness was diffuse. She stated that for two weeks after the alleged accident, she was on a 20-pound restriction and since then she was kept off work. Dr. Levin asked the Petitioner to stand on her toes but was advised that she could not do it. She also claimed she could not stand on her heels. He wanted to take x-rays but the Petitioner called her attorney and following the phone call she would not allow him to x-ray her. (Respondent Exhibit 2)

Dr. Levin reviewed Petitioner's medical records to date. He felt that the Petitioner's comment that she was 0% better and had loss of vision and vague pain going up her shoulder is inconsistent with any anatomic/physiologic pathology and reflects psychosocial issues. Petitioner's description of constant pain with all parameters of activity is also consistent with psychosocial issues. The fact that she could walk in a reciprocal heel/toe fashion but could not walk toe/toe is also inconsistent with physiological etiology of her complaints. Petitioner's diffuse tenderness and positive Hoover sign are consistent with psychosocial etiology. (Respondent Exhibit 2)

Dr. Levin felt that the findings on her 2010 MRI could be the result of daily living but even if they were, the result of this alleged accident the result would be right sided pain and not left sided as she stated to him earlier. The doctor found no medical reason to support continued treatment for her based upon all of the factors described. Even if Petitioner sustained some type of injury, it should have been resolved within 2 weeks thereafter and that Petitioner should be working full duty without restrictions. (Respondent Exhibit 2)

On 1/3/11, Petitioner sought out Dr. Graf, a spine surgeon. The Petitioner complained of pain radiating down both legs and sometimes the left leg. She claimed her left side was worse than her right. His reading of the 2010 MRI showed a left L3 nerve root disposition, which was secondary to the L3 lateral lumbar disc herniation, which he believed the MRI showed. (Petitioner Exhibit 6) Dr. Levin re-read the MRI on March 1, 2011, agreed with Dr. Graf that there is a foraminal, and far lateral L3-4 disk herniation abutting the left nerve. However, he reiterated his opinion regarding causal connection and felt further medical care was not warranted and Petitioner had reached maximum medical improvement. (Respondent Exhibit 2)

Dr. Levin, in a report dated April 15, 2011 reviewed an MRI performed on March 2, 2011. He found degenerative discs At the L3-4, L4-5, and L5-S1 levels. There was a right sided L5-S1 disk herniation with bilateral arthritis and the L4-5 level showed some fluid in the annulus centrally with arthritis greater on the left than right. The L3-4 level showed bilateral arthritis and left sided herniation. The L2-3 level showed bilateral arthritis and L1-2 showed arthritis. This new MRI did not change Dr. Levin's prior opinion regarding causation. (Respondent Exhibit 2)

On June 1, 2011, Petitioner told Dr. Graf she can no longer tolerate her symptoms and she wished to discuss surgical options. Since physical therapy made her pain worse and her prior injections did not help, Dr. Graf ordered a discogram. This discogram was performed July 2, 2011 and found that all the discs examined caused complaints of pain and therefore was found to be invalid. Dr. Graf determined that she was not a surgical candidate and ordered a functional capacity evaluation to check the validity of her complaints. (Petitioner Exhibit 6)

From the beginning of her treatment for these alleged injuries, Petitioner has been receiving prescriptions for narcotic drugs such as Tylenol 3, Tylenol 4, and Norco. She has jumped from doctor to doctor seeking narcotic medication up to and including December 18, 2014. Since Dr. Graf's February 20, 2013 visit, where he declared her at MMI, she has seen Dr. Ahmad, Dr. Mitra, Dr. Snebold, Dr. Prunkis, Dr. Erazo, and Dr. Guman in search of a never-ending prescription to narcotic drugs.

The Commission finds the reports of Dr. Jay Levin to be persuasive and more credible than the opinions of Dr. Graf. On October 30, 2012, after reviewing Dr. Graf's discogram Dr. Levin was of the opinion that Petitioner's subjective complaints do not correlate with the findings on the MRI's. After reviewing Dr. Graf's records, he was of the opinion that Dr. Graf appeared to come to the same conclusion. Dr. Levin stood by his opinion contained in the November 8, 2010 report. He does not believe that the Petitioner's significant objective complaints and mortal weaknesses that are reported in Dr. Graf's records correlate with any anatomical objective pathology. He would not have run the subsequent tests that Dr. Graf ran but the results of those tests are consistent with his interpretation that one should not treat a Patient based upon an MRI alone but the totality of the information. The fact that Petitioner demonstrated the inability to break the strength on Dr. Graf's single index finger is absolutely consistent with nonorganic pathology. Dr. Levin concluded that during his examinations of Petitioner she showed symptom magnification and malingering.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 21 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 $220.00 per week for a period of 100 weeks, as provided in §8(d) (2) of the Act, for the reason that the injuries sustained caused the loss of use to the person as a whole to the extent of 20%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

16IWCC0432

medical bills as it pertain to Petitioner's lower back up until March 11, 2011. All medical bills after that date are the responsibility of Petitioner.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,800.00. 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: JUN 27 2016

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 4/27/16
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MACIEL, NORMA
Employee/Petitioner

Case# **10WC038998**

HERITAGE WOODS OF HUNTLEY
Employer/Respondent

16IWCC0432

On 5/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

A copy of this decision is mailed to the following parties:

0140 CORTI & ALEKSY PC
JOHN C SERKLAND
180 N LASALLE ST SUITE 2910
CHICAGO, IL 60601

0210 GANAN & SHAPIRO PC
JOE BRANCKY
210 W ILLINOIS ST
CHICAGO, IL 60654

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

Norma Maciel
Employee/Petitioner
v.

Case # **10** WC **38998**

Heritage Woods of Huntley
Employer/Respondent

16IWCC0432

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Waukegan**, on **March 25, 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 **Did Petitioner exceed her choice of Physicians?**

16IWCC0432

FINDINGS

On **September 7, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**16,805.88**; the average weekly wage was $**323.19**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**5,046.56** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**5,046.56**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**253.00**/week for **124 4/7** weeks, commencing **October 1, 2010** through **February 20, 2013**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $**5,046.56** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner maintenance benefits of $**253.00**/week for **109** weeks, commencing **February 21, 2013** through **March 25, 2015**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $**466.13**/week for life, commencing **March 26, 2015**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Arbitrator Anthony C. Erbacci

May 13, 2015
Date

MAY 20 2015

FACTS:

On September 7, 2010 the Petitioner sustained undisputed accidental injuries arising out of and in the course of her employment with the Respondent as a housekeeper. The Petitioner testified as to the duties of her employment, which included cleaning and vacuuming, and the physical requirements of performing her job. The Petitioner testified that on September 7, 2010 she was vacuuming a common area of the Respondent's facility and was required to lift a sofa chair in order to vacuum underneath it. The Petitioner testified that she bent and twisted while she lifted the chair and that, as she did so, she experienced a sharp pain in her lower back. The Petitioner reported the incident to her supervisor and was directed to seek care at Centegra Occupational Health. The Petitioner testified that prior to this occurrence she had not had any injuries to her lower back and that she had never received any medical treatment or been prescribed medications for her lower back.

The Petitioner presented to Centegra Occupational Health on September 7, 9 and 16, 2010 complaining of back pain from lifting a sofa chair. She was noted to have positive straight leg raise on the right and she was given restrictions of no lifting over 10 pounds with minimal stooping, bending, twisting, pushing or pulling. The Petitioner was also referred to Majercik Physical Therapy where she underwent physical therapy from September 22, 2010 through October 25, 2010.

The Petitioner testified that she continued to work light duty from the date of the accident through October 1, 2010, but she testified that, during this period, she was still required to perform her regular job.

On September 30, 2010 the Petitioner presented to Dr. Syed Asghar, with whom she had treated previously for non-work related conditions. The Petitioner gave a history of her work injury and was noted to have complaints of back pain radiating into both legs. Dr. Asghar authorized the Petitioner off work and he ordered an MRI. The MRI was performed at Memorial Medical Center on October 8, 2010 and was reported to demonstrate a moderately protruding disc on the right at L5-S1, spinal stenosis at L3-4 and a disc bulge at L3-L4 and L4-L5 with encroachment on the left L3 nerve root. Dr. Asghar then referred the Petitioner to Dr. Khaja Nasaruddin at the Pain Center of McHenry County.

The Petitioner saw Dr. Nasaruddin on October 28, 2010 and was noted to have complaints of low back pain radiating down both legs with restricted and painful range of motion. Dr. Nasaruddin diagnosed low back pain with lumbar radiculopathy from internal disc derangement and he recommended a trial of injections and oral pain medication. He also recommended the Petitioner remain off work. On November 3, 2010, the Petitioner received a bilateral S1 transforaminal epidural steroid injection at Memorial Medical Center.

On November 8, 2010, the Petitioner was examined by Dr. Jay Levin at the request of the Respondent. Dr. Levin opined that the Petitioner had psychosocial issues, and noted that her complaints of vague, diffuse, and constant pain, along with a positive Hoover's sign, were inconsistent with any anatomic pathology. Dr. Levin noted that the Petitioner's MRI findings

were those that could be present in the general population without any clinical symptoms and that the Petitioner's current left-sided complaints were inconsistent with the right sided bulge on the MRI. Dr. Levin opined that there was no medical reason to continue treatment and that it was possible that the Petitioner did not sustain any injury. Dr. Levin opined that, if the Petitioner had sustained an injury, it was a lumbar sprain type injury which would have resolved within two weeks. Dr. Levin opined that the Petitioner had reached maximum medical improvement from her injury and could return to her regular full-duty work.

On November 10, 2010, the Petitioner returned to Memorial Medical Center and was given a lumbar epidural spinal injection at L5-S1.

The Petitioner returned to Dr. Nasaruddin on November 19, 2010. Dr. Nasarrudin noted that the Petitioner reported that there was no improvement from the two epidural injections. Dr. Nasaruddin's impression was that the Petitioner had low back pain with lumbar radiculopathy/myofascial pain and he recommended that the Petitioner start physical therapy and continue oral medications. On December 3, 2010 Dr. Nasaruddin noted that the Petitioner had complaints of radiating pain to both legs, more so on the left side, as well as restricted and painful range of motion of the lumbar spine. Dr. Nasaruddin recommended the Petitioner continue physical therapy and remain off work. On December 10, 2010 Dr. Nasaruddin drafted a letter to the Petitioner's attorney indicating that he did not believe the Petitioner's problems were psycho-social, that pathology was noted on MRI, and that the Petitioner had radiating pain into both legs. Dr. Nasaruddin also indicated that he would refer the Petitioner to a surgeon if her condition did not improve with physical therapy. Dr. Nasaruddin saw the Petitioner again on December 16, 2010 and he noted complaints of increased pain with physical therapy. Dr. Nasaruddin recommended the Petitioner remain off work and he referred her to Dr. Charles Graf of the Illinois Spine Institute.

The Petitioner saw Dr. Graf on January 3, 2011. Dr. Graf noted that the Petitioner had complaints of bilateral radiating leg pain, limited ability to squat due to pain, pain to palpation of the lumbar spine, limited flexion and extension as well positive straight leg raise bilaterally. He diagnosed the Petitioner with lumbar disc herniation at L3-L4 impinging the exiting L3 nerve root and herniation at L5-S1 impinging the S1 nerve root. Dr. Graf noted that the Petitioner's radiating left leg pain followed the L3 nerve root distribution secondary to the far lateral lumbar disc herniation which he visualized on the MRI scan. Dr. Graf recommended the Petitioner remain off work and undergo a selective nerve root block and physical therapy.

On January 12, 2011 Dr. Graf authored a letter report directed to the Petitioner's attorney. Dr. Graf outlined the Petitioner's medical treatment through that date and reported that his reading of the Petitioner's MRI was that it demonstrated a grade 1 spondylolisthesis at L3-L4 and a large far lateral disc herniation at the left at that level with impingement on the exiting L3 nerve root as well as a right sided L5-S1 disc herniation impinging on the traversing S1 nerve root. Dr. Graf opined that the Petitioner's complaints were causally related to the work injury in question.

On January 14, 2022 the Petitioner underwent the recommended nerve root block

injection which was performed by Dr. Nasaruddin at Memorial Medical Center. The Petitioner then returned to Dr. Graf on January 21, 2011 and Dr. Graf indicated that she may be a candidate for surgery and should remain off work. On January 31, 2011 the Petitioner underwent a right L3-L4 facet injection performed by Dr. Nasaruddin at Memorial Medical Center. On February 18, 2011 Dr. Graf noted complaints of severe back and bilateral radicular pain, and he recommended that the Petitioner stop physical therapy and undergo a new MRI scan.

On March 1, 2011 Dr. Levin authored an addendum report after having reviewed additional records which included the Petitioner's MRI of October 8, 2010. After his review of the MRI, Dr. Levin agreed that the Petitioner had herniated discs at L3-4, L4-5 and spondylolisthesis and he also agreed with Dr. Graf that there was a foraminal and far lateral L3-L4 disk herniation abutting the L3 nerve root. Dr. Levin reiterated his opinion that the injury sustained by the Petitioner on September 7, 2010 was likely a lumbar strain and that she had reached maximum medical improvement from that injury by November 8, 2010.

The Petitioner underwent another lumbar MRI at PRI Diagnostics on March 2, 2011. On March 9, 2011 Dr. Graf noted that the MRI demonstrated a disc herniation and grade 1 spondylolisthesis at L3-L4 causing severe lateral recess stenosis. Dr. Graf also noted that an annular tear at L5-S1 with a right paracentral disc herniation was demonstrated. Dr. Graf opined that the Petitioner's symptoms were emanating from these levels and he indicated that he could offer the Petitioner a lumbar decompression surgery but it would not improve her low back symptoms. Dr. Graf opined, however, that a lumbar laminectomy and decompression of the L3 exiting nerve root at the L3-L4 level would be a benefit to the Petitioner given the fact that she had failed conservative management. Dr. Graf recommended the Petitioner remain off work and he noted that her pain was so severe she had difficulty with activities of daily living. On June 1, 2011 Dr. Graf recommended the Petitioner undergo a discogram and he referred her to Dr. Neema Bayran for that procedure.

Dr. Bayran saw the Petitioner on June 28, 2011. Dr. Bayran noted the Petitioner's history of an injury at work on September 7, 2010 when she lifted a sofa chair to vacuum underneath and her pain started. Dr. Bayran also noted tenderness over the spinal muscles, diminished range of motion, pain with toe and heel walking, positive straight leg raise and bilateral leg pain secondary to disc protrusion and narrowing at L3-L4 and L5-S1. Dr. Bayran performed a discogram/CT scan on the Petitioner on July 2, 2011 and he noted that it reproduced concordant pain at the L3-L4 and L5-S1 levels and non- concordant pain at the L4-L5 and L2-L3 levels. Dr. Bayran noted that the post discogram/CT scan demonstrated severe spinal stenosis at L3-L4 with mild to moderate stenosis at L4-L5 and disc bulge with apparent annular tear and protrusions at L3-L4 and L4-L5. Facet arthropathy and spondylolisthesis was also noted at L3-L4.

On July 15, 2011 Dr. Graf noted that the discogram was invalid with multiple levels of pain and he indicated that the Petitioner was not a surgical candidate. Dr. Graf recommended a Functional Capacity Evaluation and continued management of her pain. On August 16, 2011 the Petitioner followed up with Dr. Bayran who prescribed medication and discussed a Spinal

Cord Stimulator trial.

On October 12, 2011, Dr. Graf noted that the Petitioner reported that her attorney had referred her to Dr. Avi Bernstein for a second opinion and that Dr. Bernstein had recommended a CT myelogram and suggested a lumbar fusion from L3 – S1 would be required. Dr. Graf reiterated his opinion that the Petitioner was not a surgical candidate, and he indicated that the CT myelogram would not add much beyond the two previous MRI studies. Dr. Graf noted that Dr. Bayran had recommended a possible spinal cord stimulator trial and indicated that he felt that was more reasonable. Dr. Graf referred the Petitioner back to Dr. Bayran for continued pain management. The Petitioner continued to follow-up with Dr. Bayran and he continued to suggest consideration of a spinal cord stimulator trial.

The Petitioner was examined again by Dr. Levin at the Respondent's request on March 29, 2012. Dr. Levin reported as to his examination findings and indicated that he would review some additional records and update his opinions and recommendations following that review. On October 30, 2012 Dr. Levin authored another report after having reviewing additional records. Dr. Levin reiterated his prior opinion that the Petitioner's work injury was nothing more than a lumbar strain and he indicated that the findings on the Petitioner's MRIs were "just degenerative in nature or even anatomically present and of no clinical significance". Dr. Levin noted that Dr. Graf ultimately came to the conclusion that the Petitioner's subjective symptoms do not correlate with a single level disease process of the lumbar spine which was a product of a traumatic injury. Dr. Levin also noted that at Dr. Graf's October 12, 2011 examination he noted that the Petitioner reported an inability to break the strength of his single index finger with her bilateral legs. Dr. Levin explained that unless the Petitioner had a spinal cord injury, this was inconsistent with organic pathology. Dr. Levin opined that he did not believe that the Petitioner's significant objective complaints and reported mortal weakness correlate with any anatomical objective pathology.

On November 1, 2012, the Petitioner reported to Dr. Bayran that her pain went into both legs, left greater than right, with numbness over the lateral aspect of her left thigh, left calf, and into her left toes. Dr. Bayran noted that the Petitioner reported she was unable to bend forward or backward even a few degrees, and that light palpation of lumbar spine caused excruciating pain in her lower back.

On January 24, 2013 the Petitioner underwent a functional capacity evaluation at ATI Physical Therapy which was reported to demonstrate that the Petitioner could perform occupational activities at a sedentary level. The Petitioner returned to Dr. Graf on February 20, 2013 and he indicated that the Petitioner was at maximum medical improvement but needed ongoing pain management. Dr. Graf released the Petitioner to return to work per the restrictions noted in her functional capacity evaluation and recommended she return to Dr. Bayran for continued pain management.

On March 31, 2013 the Petitioner underwent a vocational assessment performed by Susan Entenberg. Ms. Entenberg opined that the Petitioner was a "very poor candidate for vocational rehabilitation with no stable labor market available to her." She based her opinion

on the valid FCE, limited education to the ninth grade level, unskilled work history and lack of computer or clerical skills. Ms. Entenberg testified that there are no activities that the Petitioner could perform that would be worthy of wages and that there's "just not a labor market" for the Petitioner given her limitations.

On April 26, 2013, the Petitioner saw Dr. Mackie Snebold and requested a referral for pain management to Illinois Pain Institute and Dr. Prunskis in particular. The Petitioner reported that she was unable to sit or stand for more than 15 minutes, and that her pain was constantly at 8/10. Dr. Snebold noted that the Petitioner stated she could not lie down on the exam table due to extreme pain and that squeezing the Petitioner's calves elicited pain complaints that she claimed radiated from her back. Dr. Snebold diagnosed low back pain and lumbago and referred the Petitioner to Dr. Prunskis for pain management consultation and management.

The Petitioner saw Dr. Prunskis on April 26, 2013 and the doctor noted severe symptoms, and prescribed a lumbar MRI and bilateral leg EMG studies to determine what kind of care she would need. The Petitioner apparently did not return to Dr. Prunskis.

On November 1, 2013, the Petitioner was seen by Dr. Liliana Erazo for the first time. Dr. Erazo noted that the Petitioner was requesting referral to the Pain clinic because she needed refills of her pain medication. Dr. Erazo's assessments included low back pain, herniated disc syndrome, and chronic pain syndrome and she referred the Petitioner to Dr. Sebastian Guman.

Dr. Guman first saw the Petitioner on November 14, 2013, and he prescribed aquatic therapy and medications. The Petitioner thereafter continued to follow up with Dr. Guman and he continued to prescribe medications. The Petitioner last saw Dr. Guman on December 18, 2014.

At the request of the Respondent, the Petitioner underwent a vocational evaluation performed by vocational rehabilitation counselor Edward Steffen on February 4, 2015. Mr. Steffan reported that the Petitioner's subjective presentation would be an impediment to being hired but he opined that the Petitioner would be able to perform entry level, non-skilled jobs with a sit/stand option and that appropriate vocational counseling would likely find her a position. Mr. Steffan indicated however that it would be reasonable to be of the opinion that the Petitioner "would not be able to induce a potential employer to hire her over other employment applicants".

The Petitioner testified that she currently continues to experience pain and discomfort in her back and that she is limited in her activities of daily living by continuing pain. The Petitioner testified that she has some good days and some bad days and that, on the good days she can wash dishes and cook for her husband while on the bad days she remains inactive. The Petitioner testified that she has not worked or looked for work since September of 2010 and that she is currently receiving Social Security Disability benefits.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

It is undisputed that the Petitioner sustained an accidental injury which arose out of and in the course of her employment with the Respondent on September 7, 2010 and that notice of the injury was given to her supervisor that same day. The histories contained in the records of the Petitioner's medical treatment support her testimony that she lifted a sofa chair and felt the immediate onset of pain. The Petitioner further testified that, prior to September 7, 2010, she had not injured her back or sought any medical treatment for her back, and that she has not had any other injuries to her back since that date. The Petitioner's testimony in that regard was not rebutted or contradicted.

On the day of her injury, the Petitioner presented to the medical clinic to which she was directed by her employer and was diagnosed with a back injury and given work restrictions of no lifting over 10 pounds. The Petitioner's complaints did not improve and she sought treatment from Dr. Asghar who referred her for pain management to Dr. Nasaruddin. Dr. Nasaruddin treated the Petitioner conservatively with injections and medication and, when the Petitioner's complaints did not improve, referred her to Dr. Graf.

Dr. Graf diagnosed the Petitioner with lumbar disc herniations at L3-L4 impinging the exiting L3 nerve root and herniation at L5-S1 impinging the S1 nerve root. He recommended the Petitioner remain off work from January 3, 2011 through February 20, 2013 when he discharged her with permanent restrictions in accordance with the findings of a functional capacity evaluation that was performed on January 24, 2013. On January 12, 2011 Dr. Graf authored a letter report in which he indicated that his reading of the Petitioner's October 8, 2010 MRI was that it demonstrated a grade 1 spondylolisthesis at L3-L4 and a large far lateral disc herniation at the left at that level with impingement on the exiting L3 nerve root as well as a right sided L5-S1 disc herniation impinging on the traversing S1 nerve root. Dr. Graf opined that the Petitioner's complaints were causally related to the work injury in question.

A second lumbar MRI conducted on October 8, 2010 was reviewed by Dr. Graf who noted that the MRI demonstrated a disc herniation and grade 1 spondylolisthesis at L3-L4 causing severe lateral recess stenosis. Dr. Graf also noted that an annular tear at L5-S1 with a right paracentral disc herniation was demonstrated. Dr. Graf opined that the Petitioner's symptoms were emanating from these levels and he indicated that he could offer the Petitioner a lumbar decompression surgery but it would not improve her low back symptoms. Dr. Graf opined, however, that a lumbar laminectomy and decompression of the L3 exiting nerve root at the L3-L4 level would be a benefit to the Petitioner given the fact that she had failed conservative management. Dr. Graf recommended the Petitioner remain off work and he noted that her pain was so severe she had difficulty with activities of daily living. On June 1, 2011 Dr. Graf recommended the Petitioner undergo a discogram and he referred her to Dr. Neema Bayran for that procedure.

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Dr. Bayran performed a discogram/CT scan on the Petitioner on July 2, 2011 and he noted that it reproduced concordant pain at the L3-L4 and L5-S1 levels and non- concordant pain at the L4-L5 and L2-L3 levels. Dr. Bayran noted that the post discogram/CT scan demonstrated severe spinal stenosis at L3-L4 with mild to moderate stenosis at L4-L5 and disc bulge with apparent annular tear and protrusions at L3-L4 and L4-L5. Facet arthropathy and spondylolisthesis was also noted at L3-L4. On July 15, 2011 Dr. Graf noted that the discogram was invalid with multiple levels of pain and he then indicated that the Petitioner was not a surgical candidate. Dr. Graf recommended the Petitioner submit to a functional capacity evaluation and continue with pain management.

While the Arbitrator notes the opinions of Dr. Levin, the Arbitrator also notes that the evidence demonstrates that the Petitioner was in relatively good health, without any prior back injuries or treatment, and was able to perform all of the duties of her employment prior to the undisputed work injury on September 7, 2010. The Petitioner sought medical treatment immediately following the injury and underwent a continuing course of medical treatment after that accident. Although Dr. Levin dismissed the Petitioner's complaints as being due to psychosocial issues, and inconsistent with any anatomic pathology, he agreed that the Petitioner had herniated discs at L3-4, L4-5 and spondylolisthesis and he also agreed with Dr. Graf that there was a foraminal and far lateral L3-L4 disk herniation abutting the L3 nerve root. Dr. Nasaruddin indicated that he did not believe the Petitioner's problems were psycho-social and he noted that pathology was noted on the Petitioner's MRI. Dr. Graf noted that the Petitioner's MRI demonstrated a disc herniation and grade 1 spondylolisthesis at L3-L4 and an annular tear at L5-S1 with disc herniation and he opined that the Petitioner's symptoms were emanating from these levels. Dr. Graf also opined that the Petitioner's complaints were causally related to the work. The Arbitrator finds the opinions of Dr. Levin to be unpersuasive in the instant matter.

Based upon the foregoing, and having considered the totality of the evidence adduced at hearing, the Arbitrator finds that the Petitioner's present condition of ill-being is causally related to the Petitioner's work injury of September 7, 2010.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, and (O.), Did Petitioner exceed her choice of physicians, the Arbitrator finds and concludes as follows:

The Arbitrator has found that the Petitioner's current condition of ill-being is causally related to her work injury and, thus, finds that the medical treatment that was provided to the Petitioner was reasonable and necessary to cure or relieve the effects of her occupational injury. This conclusion is based on the medical records, Petitioner's unrebutted testimony and Dr. Graf's recommendation that the Petitioner continue pain management for the relief of her symptoms.

The Petitioner offered evidence of unpaid medical bills totaling $7,162.26 for treatment received from Greater Elgin Pain Management, Majercic Physical Therapy, Illinois Spine Institute, Occucare Systems, Northwest Surgical Specialists, Lindenhurst Anesthesia and ATI Physical Therapy. The Arbitrator awards $7,162.26 for medical expenses, subject to the fee schedule and the analysis below.

With regard to the issue of whether the Petitioner exceeded her choice of physicians, the Arbitrator notes that the Petitioner's first choice of physicians was Dr. Asghar, who referred her to Dr. Nasaruddin who then referred her to Dr. Graf. Dr. Graf referred the Petitioner to Dr. Bayran, his partner, for pain management. In September of 2011 the Petitioner saw Dr. Avi Bernstein for a second opinion but she received no actual treatment from Dr. Bernstein. The Petitioner also saw Dr. Sanjukta Mitra on June 18, 2012. The Petitioner testified that she only saw Dr. Mitra on one occasion and that he did not render any treatment to her. After Dr. Graf placed the Petitioner at maximum medical improvement on February 20, 2013 he recommended that she continue to seek pain management with Dr. Bayran. The Petitioner testified that subsequent to her release by Dr. Graf, her group insurance coverage changed and she was compelled to seek treatment from a physician other than Dr. Bayran, who was not within her group coverage. The Petitioner then saw her primary care physician, Dr. Snebold, who referred her to Dr. Prunskis. The Petitioner saw Dr. Prunskis on one occasion. The Petitioner next sought treatment from Dr. Erazo for her unrelated asthma, and Dr. Erazo referred her to Dr. Guman. The Petitioner treated with Dr. Guman from November of 2013 through December of 2014.

The Arbitrator finds that the Petitioner's second choice of physician was Dr. Bernstein whom she saw for a second opinion. Dr. Bernstein examined the Petitioner and made treatment recommendations for the Petitioner pending additional diagnostic testing. The Petitioner declined to undergo the testing recommended by Dr. Bernstein and she returned to Dr. Graf. The Petitioner then sought treatment from Dr. Mitra who could be considered to be her third choice of physician. The Petitioner then saw Dr. Snebold who referred her to Dr. Prunskis. Assuming that neither Dr. Bernstein nor Dr. Mitra constituted a "choice of physician", Dr. Snebold would be the Petitioner's second choice and Dr. Prunskis would be in that chain of referrals. Dr. Erazo and Dr. Guman clearly fall outside of the Petitioner's two choices of physicians.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner testified that following her injury she continued to work modified duty until she was recommended off work By Dr. Asghar. Dr. Asghar's records demonstrate that when he saw the Petitioner on September 30, 2010, he recommended the Petitioner off work. Thereafter, the Petitioner was continued off work by her treating physicians until February 20, 2013 when Dr. Graf declared her to be at maximum medical improvement and he released

her to return to work per the restrictions noted in her functional capacity evaluation of January 24, 2013. That functional capacity evaluation was reported to demonstrate that the Petitioner could perform occupational activities at a sedentary level. The Respondent did not offer the Petitioner employment within the restrictions indicated by the functional capacity evaluation.

On March 31, 2013 the Petitioner underwent a vocational assessment performed by Susan Entenberg. Ms. Entenberg opined that the Petitioner was a "very poor candidate for vocational rehabilitation with no stable labor market available to her." She based her opinion on the valid FCE, limited education to the ninth grade level, unskilled work history and lack of computer or clerical skills. Ms. Entenberg testified that there are no activities that the Petitioner could perform that would be worthy of wages and that there's "just not a labor market" for the Petitioner given her limitations. The Petitioner also underwent a vocational evaluation performed by vocational rehabilitation counselor Edward Steffen on February 4, 2015. Mr. Steffan reported that the Petitioner's subjective presentation would be an impediment to being hired but he opined that the Petitioner would be able to perform entry level, non-skilled jobs with a sit/stand option and that appropriate vocational counseling would likely find her a position. Mr. Steffan indicated however that it would be reasonable to be of the opinion that the Petitioner "would not be able to induce a potential employer to hire her over other employment applicants".

No vocational assistance was offered to the Petitioner and there is no indication that the Petitioner requested any vocational assistance. The Petitioner testified that she has not looked for any work nor has she worked in any capacity since she was released to restricted work by Dr. Graf.

Based upon the foregoing, and having considered the totality of the evidence adduced at hearing, the Arbitrator finds that the Petitioner was entitled to Temporary Total Disability benefits from October 1, 2010 through February 20, 2013, a period of 124 4/7 weeks. The Arbitrator further finds that the Petitioner was entitled to maintenance benefits from February 21, 2013 through March 25, 2015, a period of 109 weeks.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

On February 20, 2013 Dr. Graf declared the Petitioner to be at maximum medical improvement, except for continued pain management, and he released her to return to work per the restrictions noted in her functional capacity evaluation of January 24, 2013. That functional capacity evaluation was reported to demonstrate that the Petitioner could perform occupational activities at a sedentary level. The Respondent did not offer the Petitioner employment within the restrictions indicated by the functional capacity evaluation. No vocational assistance was offered to the Petitioner and there is no indication that the Petitioner requested any vocational assistance. The Petitioner testified that she has not looked for any work nor has she worked in any capacity since she was released to restricted work by Dr. Graf.

On March 31, 2013 the Petitioner underwent a vocational assessment performed by Susan Entenberg. Ms. Entenberg opined that the Petitioner was a "very poor candidate for vocational rehabilitation with no stable labor market available to her." She based her opinion on the valid FCE, limited education to the ninth grade level, unskilled work history and lack of computer or clerical skills. Ms. Entenberg testified that there are no activities that the Petitioner could perform that would be worthy of wages and that there's "just not a labor market" for the Petitioner given her limitations. The Petitioner also underwent a vocational evaluation performed by vocational rehabilitation counselor Edward Steffen on February 4, 2015. Mr. Steffan reported that the Petitioner's subjective presentation would be an impediment to being hired but he opined that the Petitioner would be able to perform entry level, non-skilled jobs with a sit/stand option and that appropriate vocational counseling would likely find her a position. Mr. Steffan indicated however that it would be reasonable to be of the opinion that the Petitioner "would not be able to induce a potential employer to hire her over other employment applicants".

The Arbitrator notes that the Petitioner is not obviously unemployable and there is no medical evidence which supports a determination that she is permanently and totally disabled. The Arbitrator also notes that the Petitioner testified that she has not looked for any type of work since her release by Dr. Graf on February 20, 2013. The testimony and opinions of Susan Entenberg, however, support the conclusion that the Petitioner is not employable in any stable labor market and therefore fits into the "odd lot" category of permanent disability. The Arbitrator also notes that while Mr. Steffan opined that the Petitioner would be able to perform entry level, non-skilled jobs with a sit/stand option and that appropriate vocational counseling would likely find her a position he also opined that the Petitioner's subjective presentation would be an impediment to her being hired and that it would be reasonable to be of the opinion that the Petitioner "would not be able to induce a potential employer to hire her over other employment applicants". While the Arbitrator is reluctant to find the Petitioner to be permanently and totally disabled, the evidence in the record compels such a finding.

Based upon the foregoing, and having considered the totality of the evidence adduced at hearing, the Arbitrator finds that the Petitioner is permanently and totally disabled as of March 25, 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 COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marcos Mireles,
Petitioner,

vs. NO: 10WC 10320

Mike Balter Mallets, LLC.,
Respondent,

16IWCC0433

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, benefit rates, incurred medical, prospective medical, notice, causal connection, temporary total disability, permanent partial disability, penalties, fees, evidentiary issues and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 3, 2014, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing 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: JUN 2 7 2016
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CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MIRELES, MARCOS
Employee/Petitioner

Case# 10WC010320

MIKE BALTER MALLETS LLC
Employer/Respondent

16IWCC0433

On 10/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1922 SALK, STEVEN B & ASSOC LTD
150 N WACKER DR
SUITE 2570
CHICAGO, IL 60606

2999 LITCHFIELD CAVO LLP
JONATHAN E BARRISH
303 W MADISON ST SUITE 300
CHICAGO, IL 60606-3309

☐	Injured Workers' Benefit Fund (§4(d))
☐	Rate Adjustment Fund (§8(g)
☐	Second Injury Fund (§8(e)18)
☒	None of the above

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

MARCOS MIRELES
Employee/Petitioner

Case #10 WC 10320

v.

MIKE BALTER MALLETS, LLC.
Employer/Respondent

16IWCC0433

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on January 28, 2013, February 20 and 24, 2013, April 24, 2013, December 4, 2013, June 25, 2014, and August 26, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☐ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

L. ☐ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On January 15, 2010, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- In the year preceding the injury, the petitioner earned $19,760.00; the average weekly wage was $380.00.

ORDER:

- The petitioner's request for benefits is denied and the claim is dismissed.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E. Williams

Signature of Arbitrator

October 3, 2014

Date

OCT 3 - 2014

FINDINGS OF FACTS:

On January 27, 2010, the petitioner sought chiropractor care with Dr. Mohamed Malas at Family Medical and Chiropractic and complained of neck, upper back and right shoulder pain since January 15th while pressing down a press machine. His pain diagram described aching upper back and neck pain and burning pain in his right upper back and shoulder blade area. He was given shoulder massages and cervical manipulations from C3 through T4 a few times through February 3rd. The petitioner did not work from January 27, 2010, through February 14, 2010.

On February 8, 2010, the petitioner saw Dr. Raab at Illinois Bone and Joint for neck and shoulder pain that begins in his neck and goes into his shoulder. Dr. Raab noted a full range of motion for his right shoulder with positive impingement signs, significant neck pain with range of motion without any radicular symptoms. Cervical and right shoulder x-rays were unremarkable. His diagnosis was right shoulder impingement syndrome and cervical strain for which he prescribed medication and therapy. A cervical MRI on March 9th revealed a minimal bulge at C5-6 without significant central or foraminal stenosis. Dr. Raab restricted the petitioner's work on March 15th.

The petitioner began treating at Marque Medicos with Lorena Ramirez, a chiropractor, on March 16th and received physical therapy and chiropractic modalities through June 24th. An NCV/EMG study of his cervical and right upper extremity on March 19th was negative for peripheral entrapment or polyneuropathy. An MRI of his right shoulder on March 22nd revealed an intact rotator cuff and tendonitis and/or bursitis involving the distal supraspinatus tendon. A right shoulder x-ray on March 24th was unremarkable. Dr. Engel of Medicos Pain & Surgical Specialists started pain

management on March 30th and followed up with him through June 25th. A cervical MRI on April 2nd revealed bulges at C3-4 and C4-5 without spinal stenosis or foraminal narrowing.

At the request of the respondent, Dr. Mark Levin evaluated the petitioner on April 12, 2010, and opined on June 25, 2014, that the petitioner had multiple subjective areas of discomfort that did not conform with any objective pathology that could be explained by his work activities; and, that a job video of the arm positions and standing posture required for the performance of the petitioner's job duties did not cause or aggravate his condition of ill-being. Dr. Levin further opined and demonstrated that the cause of shoulder impingement is abduction of the arm greater than 90 degrees, which was not done to emboss the drumsticks.

An MRI of his right shoulder on April 28th revealed tendonitis of the supraspinatus and infraspinatus tendons. A valid functional capacity evaluation on May 25th demonstrated physical capabilities at the medium physical demand level. Dr. Nam of Medicos Pain & Surgical Specialists saw the petitioner for his right shoulder on March 29th and rendered care through October 4th for a right shoulder impingement syndrome and possible labral tear. On July 26th, Dr. Nam released the petitioner to restricted work. He was discharged and released to full-duty work October 5, 2010.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony, the evidence submitted and the job video, the petitioner failed to prove that he sustained an accident on January 15, 2010, arising out of and in the course of his employment with the respondent. The three primary tasks the petitioner performed – cutting drumsticks, trimming and embossing them – were all done

by a machine and required minimum effort from him. The embossing – the task the petitioner attributed as the cause of his symptoms – involved the use of a machine with a lever at the level of his shoulder and pulling the lever down a short distance with his arm close to his body. The process requires only slight force while looking at the drumsticks with possibly a slight tilt of the head. It is not believable that those tasks even though repeated over and over throughout his eight-hour day would aggravate or cause a cervical strain and a shoulder impingement. The opinion of Dr. Levin regarding the petitioner's standing posture and arm positions not being a cause or aggravation of his condition is credible. The opinions of Drs. Ramirez, Nam, Raab and Engels are not consistent with the evidence nor are the opinions supported by a sufficient medical basis. Their opinions are conjecture and are unsupported legal conclusions. The petitioner's request for benefits is denied and the claim is dismissed.

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

Alvin Chacko,

Petitioner,

vs. NO: 14WC 18959

Chicago Transit Authority,

Respondent,

16IWCC0434

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, permanent partial disability, medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

16IWCC0434

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 $18,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 2 7 2016
o062216
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

CHACKO, ALVIN
Employee/Petitioner

Case# 14WC018959

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

16IWCC0434

On 5/26/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2559 BOWMAN & BOWMAN LTD
LANE ALLEN CORDAY
134 N LASALLE ST SUITE 1440
CHICAGO, IL 60602

0515 CHICAGO TRANSIT AUTHORITY
DEREK FALLSTROM
567 W LAKE ST 6TH FL
CHICAGO, IL 60661-1465

16IWCC0434

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)

Alvin Chacko
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # 14 WC 18959

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen Friedman**, Arbitrator of the Commission, in the city of **Chicago**, on **April 8, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **December 17, 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 $**68,466.32**; the average weekly wage was $**1,316.66**.

On the date of accident, Petitioner was **25** 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 $**36,866.52** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**36,866.52**.

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 $877.77/week for 55 6/7 weeks, commencing December 18, 2013 through March 31, 2014, June 10, 2014 through October 1, 2014, and October 18, 2014 through April 8, 2015 as provided in Section 8(b) of the Act. Respondent shall be given a credit of $**36,866.52** for TTD paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,400.00 to Dr. Elkun, $478.00 to Dr. McKenzie, $150.00 to Chicago Imaging, $669.00 to Midwest Imaging Professionals and $2,370.00 to Advocate Trinity Hospital, as provided in Sections 8(a) and 8.2 of the Act. Pursuant to the stipulation of the Parties, Respondent shall be given a credit for any medical benefits that have been paid against these bills since the date of Arbitration.

Respondent shall also reimburse Petitioner $194.00 for payments made to Dr. McKenzie.

Respondent shall authorize and pay for additional reasonable and necessary treatment for Petitioner consistent with the recommendations of Dr. Leonard Elkun and Dr. Andrew McKenzie including the recommended referral to Dr. Bonita Alexander of RIC and including, related services, and other reasonable, necessary and causally connected treatment prescribed.

Respondent also shall authorize and pay for additional reasonable and necessary treatment including referral, evaluation and treatment for bilateral knee pain by an orthopedic specialist, Dr. Greg Fahrenbach including, related services, and other reasonable, necessary and causally connected treatment prescribed.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

May 26, 2015
Date

ICArbDec19(b)

MAY 2 6 2015

Statement of Facts

Petitioner Alvin Chacko testified that he is 27 years old and was employed by the Chicago Transit Authority (CTA) in December, 2013 as a Product Engineer III. He had been hired on January 28, 2013. He was responsible for technical support to the CTA's seven garages, with main responsibility for the two northern garages. His duties involved testing new products, technologies, software and systems on existing transit systems, preparing procedural bulletins and participating in cost savings programs (Px 23). Petitioner testified as to his projects, contributions and proposals while employed by Respondent

Petitioner testified he had received double engineering degrees from DeVry University; a Bachelor of Science in Biomedical Engineering Technology and a Bachelor of Science in Electronic Engineering Technology (Px 23). He testified to his projects and responsibilities at Newark, his previous employer, during his 19 months of employment there. He testified his nickname was "Spunky." He testified his prior employer offered to match his salary at Respondent, but he wanted to work in the public sector.

Petitioner testified that in December 2013, he was assigned the task of monitoring the Ventra System on the CTA buses. He was to ride 10 buses a day for the week, observe the system, track customer complaints and discuss his findings with his manager and the chief engineer. On December 17, 2013 he was riding a CTA bus as part of the project. His assignment was to sit near the Ventra box and document customer complaints. As he was seated in the first row near the Ventra box, the bus was involved in an accident and collided with a post on the sidewalk. Petitioner stated he hit his head on a metal stanchion and fell onto his back as a result of the impact. Petitioner testified that he saw stars, and that people were gathered around him while he was on the floor after the accident. The most obvious injury was a large laceration to his right forehead above the eye (Px 1). Petitioner testified that other passengers were injured in the accident, including an elderly man in his 80's, who was hollering and screaming and didn't want anybody to touch him.

Petitioner testified he was transported by ambulance with that elderly man to Our Lady of the Resurrection Medical Center Emergency Room (Px 3). At Our Lady of the Resurrection, he was treated for the head injury and laceration, neck, chest, left wrist and knee injuries. (Px 3, pp 6, 8) CT Scans were ordered of the head and cervical spine, in addition to x-rays of his chest, left wrist and bilateral knees (Px 3, pp 9-10). At the hospital, he stated he "saw stars" after striking his head in the accident, and denied loss of consciousness

(Px 3, p 6). Petitioner testified he was later advised by treating doctors that "seeing stars" was akin to some loss of consciousness. He was discharged and advised to follow-up with his family physician.

Petitioner testified that he began treatment with his family physicians, Dr. Shah and Dr. Patel. The records of Dr. Patel were admitted as Petitioner's Exhibit 4. Petitioner was seen on December 24, 2013 noting injuries to the head, chest wall and left wrist. He was assessed with a chest wall contusion, headache and wrist sprain. The December 31, 2013 office note also records the injury to the knees, noting knee pain without any obvious signs of damage. A CT Scan of his chest on January 10, 2014 demonstrated fracture of the right fifth rib, which corroborated his complaints of chest pain and difficulty breathing. Petitioner also advanced complaints of worsening neck pain and was diagnosed with a cervical sprain. Petitioner continued to treat with Dr. Patel and Dr. Shah for complaints of neck, chest and knee pain.

A course of physical therapy was undertaken at NovaCare from February 7, 2014 through April 17, 2014. The NovaCare records were admitted as Petitioner's Exhibit 6. Petitioner's initial complaints were neck and back pain, headaches, knee pain and buckling, loss of weight. Therapy was initially focused on the neck and back injuries, and then the bilateral knees were treated. The April 17, 2014 note reflects that Petitioner reported his neck pain was resolving, his headaches were getting less frequent, but his bilateral knee pain was not improving.

On March 19, 2014, Petitioner was seen for a Section 12 exam by Dr. Vijay Thangamani of M&M Orthopaedics, at Respondent's request. The report was admitted as Respondent's Exhibit 2. Dr. Thangamani examined only the neck and chest. The doctor recommended continued physical therapy for another four weeks, anti-inflammatory medications and muscle relaxants were necessary. He opined that the Petitioner's complaints are the direct and proximate result of the injuries sustained on December 17, 2013. He opined that Petitioner could work full time with restrictions; no lifting greater than 10 pounds, sitting job, minimal walking, minimal bending and stooping, and no hazardous or fast moving machinery. These restrictions would apply for four weeks until he completed physical therapy. The doctor would expect MMI around April 17, 2014. The doctor did believe that the extent of disability was out of proportion to the objective findings. He would have expected more improvement in neck range of motion, strength and pain. The patient's effort was suboptimal and he appeared to be guarding against full strength when testing, specifically, neck flexion and extension. While it is common to have persistent pain for some time with a rib fracture, Dr. Thangamani states Petitioner is progressing slower that he would anticipate. He notes the weakness in the right arm is unrelated to the rib fracture.

Petitioner testified that he returned to sedentary duty on April 1, 2014. He was assigned to desk work and reports. He testified that he was not understanding and retaining information. Simple tasks took him a long time and he did them wrong. He was given the assignment of monitoring and compiling the weekly Safety Vision's (SV) camera vendor score card. His supervisor sat with him the majority of the day on April 2, 2014 and then again on April 3 and 4 explaining the assignment in detail (Px 21). Petitioner testified that at that time, he was having difficulty learning and understanding the new concepts. This was a task that an ordinary technician would learn in 40 minutes. Petitioner was an engineer having great difficulties with cognitive abilities. He felt like a different person, he was not the same guy. On April 15, 2014, Petitioner received a Written Warning for Poor Work Performance for multiple errors from his supervisor, Theresa Williams, specifically addressing the situation regarding the April 2, 3 and 4 incidents, in addition to April 7 and 11, 2014 (Px 21).

Petitioner continued to work at his assignments and on June 2, 2014 was again issued a Written Warning, with Five Day Suspension and Performance Improvement Plan for mistakes relating to assignments of April 1, 7, May 6, 12 and 18 (Px 22). Petitioner testified that he was having difficulty cognitively processing information. He was making errors that never would have happened to him in the past; prior to his injury. As he had an excellent work record, this was very troubling to him.

On May 30, 2014, Petitioner reported to Dr. Shah that he has been having worsening headaches with dizziness (Px 4). Dr. Shah diagnosed headaches likely related to concussion and ordered an MRI of the brain. He presented to Dr. Patel on June 9, 2014 with worsening headaches and fatigue. He notes that he is not able to concentrate, or learn anything and the he is "not the same person." He was referred to Dr. Barras for a neuropsychological evaluation. He was already scheduled with a neurologist (Px 4). Dr. Shah took Petitioner off work on June 16, 2014 due to worsening headaches.

The MRI of the brain was performed on June 11, 2014. The reason given was headaches, nose bleeds and fatigue. The MRI was reported as normal (Px 5). Petitioner was seen in the emergency room on June 16, 2014 for headaches with nausea and vomiting (Px 20).

Petitioner was initially seen by neurologist, Dr. Violeta Avramov on June 26, 2014. Dr. Avramov's records were admitted as Petitioner's Exhibit 5. Petitioner provided a history of previous excellent health and the bus accident in December, 2013. He reports that he lost consciousness, is uncertain how long, and woke up and felt blood coming through his nose. He was complaining of severe headaches, dizziness, poor memory, poor focusing and concentration, difficulty learning, irritability, change of personality, unable to sleep, blurry vision and weight loss. He also complained of episodes of shaking uncontrollably. Dr. Avramov's assessment was concussion and prolonged post-concussion syndrome, post traumatic migraine headaches and adjustment disorder with anxiety and insomnia. Petitioner was kept off work. Depakote was prescribed and an EEG ordered. On July 14, 2014, his headaches were less frequent and less intense, with affect brighter. Depakote was increased to 1000mg daily, and he was kept off work. Assessment of concussion and prolonged post-concussion syndrome, post traumatic headaches and adjustment disorder remained the same. The EEG was performed on August 4, 2014 and was reported as normal.

On June 27, 2014, Petitioner was seen by Dr. Joshua Barras for neuropsychological examination. His report dated, July 14, 2014 was admitted as Petitioner's Exhibit 7. Petitioner was given a battery of tests. Petitioner testified that he was nervous and stressed by the testing. Memory tests showed impairment in some areas, but Dr. Barras found some results to be inconsistent likely secondary to uneven effort and attention during testing. Performance on tests of complex problem solving ranged from normal to slightly impaired. Petitioner had difficulty thinking flexibly and generating alternative strategies when given feedback that certain responses were incorrect. Dr. Barras' diagnostic impressions were: 1) mild traumatic brain injury, 2) post-concussion syndrome, 3) inconsistency to mobilize appropriate effort during neurocognitive testing noting that the memory and executive function deficits are not consistent with the mild severity of his injury, and 4) adjustment disorder with depressed mood. Dr. Barras reassured the Petitioner that he had a very mild concussion head injury and that vast majority of people who suffer such injuries have a full recovery; and encouraged him to resume fitness activities and to return to work in the near future, perhaps initially on part-time basis; and if he had persistent irritability and somatic preoccupation, that he would benefit from cognitive-behavior therapy and a trial of SSRI medication such as Lexapro.

Petitioner was seen again by Dr. Avramov on July 13, 2014 and September 14, 2014. Her assessment remained the same, but she added a diagnosis of somatic preoccupation. She noted improvement. Petitioner indicated he would like to go back to work with restrictions. Dr. Avramov prescribed cognitive-behavior therapy and Lexapro, as suggested by Dr. Barras. She also prescribed orthopedic consult for Petitioner's bilateral knee pain. She released him to return to work, starting with routine, low complexity work for the first month (Px 5).

On September 10, 2014 Petitioner underwent an IME with Dr. Andrew Zelby, a Board Certified Neurosurgeon and Assistant Professor of Neurosurgery at Rush University Medical Center. His report was admitted as Respondent's Exhibit 3. Dr. Zelby reviewed Petitioner's treatment records and performed a physical examination. He recorded a completely normal neurologic exam and normal spine exam. Dr. Zelby noted all of Petitioner's diagnostic studies are completely normal. He opined that there were no objective findings and no objective medical evidence to support Petitioner's ongoing subjective complaints. Dr. Zelby further stated that Petitioner's reported persistence and reported severity of symptoms are inconsistent with the objective medical findings and inconsistent with the natural history of his objective medical condition. The doctor also noted Petitioner's neuropsychological testing suggests an element of deception. Regarding Petitioner's self-reported incidents of involuntary shaking of the arms and legs, Dr. Zelby stated that is neuro-physiologically impossible. He opined that Petitioner reached maximum medical improvement by May, 2014.

Petitioner testified that he returned to work on October 1, 2014 with restrictions. He returned pursuant to Dr. Avramov's September 17, 2014 physical capacity evaluation (Px 8). Petitioner was allowed to do routine work, data entry and cannot be left alone. Petitioner saw Dr. Avramov on October 9, 2014 noting improvement with less frequent and less intense headaches and less frequent dizzy spells. He advised he is driving now stating he has no choice, has to get to work. He complained of knee pain. Petitioner was told he was getting better, but needed time. Petitioner was also referred for further evaluation and treatment for his knees on October 9, 2013 (Px 5).

On October 7, 2014, Petitioner was seen by clinical psychologist Dr. Andrew McKenzie of the Gersten Center for Behavioral Health. Dr. McKenzie's records were admitted as Petitioner's Exhibits 10 and 11. Petitioner related to Dr. McKenzie that he was involved in an accident while riding on a CTA bus and "lost consciousness, experienced mild traumatic brain injury, dislocated his shoulder, and injured cartilage in his knee. He reported the most traumatic aspect was regaining consciousness and seeing all the other injured passengers. Dr. McKenzie notes distractibility and anxiety. Dr. McKenzie diagnosed Post Traumatic Stress Disorder with development of depressive symptoms. Dr. McKenzie's plan was behavioral and cognitive strategies to reduce symptoms (Px 10). Petitioner had follow up sessions on October 14 and 21, 2014.

Petitioner was next seen on November 25, 2014. The record notes the Petitioner has been unable to afford weekly treatment sessions. Petitioner requested a return to work form. Dr. McKenzie noted concerns as to Petitioner's readiness for work. Dr. McKenzie completed the CTA Physical Capacities Evaluation dated November 25, 2014, requested accommodated work restrictions due to Petitioner's traumatic brain injury. The doctor stated tasks involving spatial formation, pattern formation and process formation would be very difficult and exacerbated by his PTSD symptoms. Please offer job restructuring, or if need be, relocation to a different department or position. Dr. McKenzie notes that he is only releasing Petitioner to work because he insisted due to pressure to return from his employer (Px 10). Petitioner completed a request for reasonable accommodation with respondent on December 7, 2014 (Px 23).

Petitioner continued treatment with Dr. McKenzie from January 16, 2015 thru March 23, 2015 (Px 11). Dr. McKenzie's correspondence states Petitioner continues to struggle with severe symptoms of PTSD and recommends specialized treatment for the effects of the PTSD and brain injury.

On January 21, 2015, Petitioner came under the care of psychiatrist, Dr. Leonard Elkun, having been referred by Dr. McKenzie. Petitioner received treatment from Dr. Elkun from January 21 through March 24, 2015 (Px 12, 13). Dr. Elkun notes Petitioner is suffering psychologically, his emotional reaction being the result of his altered cognitive functioning and different personality functioning. He also reports a number of physical symptoms. Dr. Elkun opines that Petitioner is suffering with signs and symptoms consistent with Post Traumatic Brain Injury, with secondary psychological and emotional conditions, being reactions to the effects of that organic injury. The psychological conditions include the diagnoses of Major Depressive Disorder, Anxiety Disorder and Delusional Disorder. Dr. Elkun opined that Petitioner will require on-going neurological intervention, as well as on-going psychiatric intervention. He recommended that Petitioner be seen, evaluated and treated for his traumatic brain injury by Dr. Bonita Alexander of RIC. Currently prescribed medications are Depakote to control moods and headaches; Lexapro, an antidepressant psychotropic drug; and Risperdal, an antipsychotic drug (Px 13). Dr. Elkun opined that Petitioner was unable to return to work and that his condition was direct result of his work related accident on December 17, 2013 (Px 12).

On February 3, 2015, Petitioner was sent for a Section 12 exam with neuropsychologist Dr. David Hartman. The report of the examination was admitted as Respondent's Exhibit 4. Dr. Hartman administered several cognitive and personality tests. Dr. Hartman also noted that Petitioner reported true auditory hallucinations (Rx 4 p. 8). Petitioner reported hearing harsh voices telling [him] to beat somebody up. Dr. Hartman stated that Petitioner does not now and never did have diagnosable Posttraumatic Stress Disorder because his involvement in the bus accident does not come close to satisfying the gateway criteria for PTSD in the Diagnostic and Statistical Manual of mental disorders (Rx 4, p. 22). He noted that gateway criteria for PTSD include a level of trauma that is much more severe than any of record for Petitioner. Moreover, Dr. Hartman felt the Petitioner's diagnosis of post-concussion syndrome was also incorrect (Rx 4 p. 24). Dr. Hartman noted the records he reviewed provided no evidence of an actual concussion. The doctor stated that even if Petitioner did sustain a concussion, it would have been mild enough for him to present normally to medical personnel, and this level of concussion is not associated with the chronic and severe neuropsychological problems that Petitioner has alleged (Rx 4 p. 25). He further noted Petitioner's claims of true auditory hallucinations and self-cutting, if valid, would not be seen in either post-concussion syndrome or PTSD.

Dr. Hartman concluded that no psychological or psychiatric medication and treatment is directly related to the December 17, 2013 accident. Psychotherapy is excessive, unreasonable, unnecessary and based on an incorrect diagnosis; and psychiatric medication management related to the accident in question is not necessary. The Petitioner is using an incident with no objective evidence of chronic injury to claim chronic subjective impairment in the context of secondary gains that include work avoidance and compensation. His diagnosis was that of malingering; rule out Schizophrenia. Petitioner is capable of working full duty with no restrictions if he does not have a Schizophrenic Disorder. If he does have a Schizophrenic Disorder, he would require medication management and psychiatric monitoring to determine when he is capable of returning to work. The claimant has reached MMI from a psychological and neuropsychological standpoint. There is no psychological or neuropsychological disability related to the accident in question (Rx 4).

Petitioner testified that he is active on social media platforms, such as Facebook. Petitioner's Facebook posts from April 2014 through February 2015 were admitted as Respondent's Exhibit 5. The posts include a range

from commentary about sporting events to remarks about girls and cereal. He also posted pictures, including images of his family and a picture of himself standing on top of a fire engine while drinking a beer. Petitioner testified that the picture of him on a fire engine was taken during a Fourth of July block party.

Respondent also admitted an investigation log of surveillance performed on Petitioner on October 7, 2014 as Respondent's Exhibit 6. The surveillance captured Petitioner travelling by car to two different banks and then stopping at a grocery store on October 7, 2014.

Respondent reinstated temporary compensation December 10, 2014 through March 3, 2015 while the request for accommodation was being addressed. On or about March 16, 2015, Petitioner received correspondence from Respondent regarding his request for accommodation which stated that "the Committee has determined that you cannot perform the essential functions of your position, Product Engineer III, nor is the Committee aware of a reasonable accommodation that would permit you to perform that position with your current medical restrictions. The Committee is also not aware of an open position at CTA that you are qualified for and would be able to fill, based on your current medical restrictions" (Px 24).

Petitioner testified that he continues to seek treatment from Dr. McKenzie and Dr. Elkun, and that treatment from was helpful in dealing with his depression, anxiety and irritability, and loss of cognitive abilities. He testified that he wants to return to work, and had requested accommodation on several occasions.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Petitioner sustained an undisputed accident on December 17, 2013 when the bus on which he was riding struck a post. The severity of the force of the blow is documented by the injury to Petitioner's forehead and the fractured rib sustained. Although Petitioner initially denied losing consciousness, he did report seeing stars. The initial medical records document multiple injuries including his head, chest, and knees. His initial treatment focused on the physical complaints being advanced. Respondent had Petitioner evaluated by an orthopedist for neck and chest symptoms only. Petitioner returned to work on April 1, 2014 based upon improvement in these neck and chest symptoms.

Upon his return to work, he noticed the cognitive deficits while trying to do his work assignments. The Petitioner's unrebutted testimony, supported by his resume and the assignments he had completed prior to the accident support his previous ability to perform at a very sophisticated level. His ability to describe the tasks and projects he had previously completed is not inconsistent with his documented deficiencies demonstrated by the disciplinary reports generated by Respondent. The Arbitrator heard the Petitioner's testimony and observed his demeanor. The Arbitrator does not find any basis to believe that Petitioner sabotaged his return to work and finds no basis to believe that Petitioner did not give his best effort to perform the tasks assigned at that time.

Following the April, 2014 return to work, Petitioner returned to Dr. Shah and Dr. Patel with complaints of worsening headaches, dizziness and the cognitive difficulties. He was referred to Dr. Avramov who diagnosed concussion and prolonged post-concussion syndrome, post traumatic migraine headaches and adjustment disorder with anxiety and insomnia. Petitioner was seen for a neuropsychological evaluation by Dr. Barras.

While Dr. Barras found inconsistencies, he diagnosed 1) mild traumatic brain injury, 2) post-concussion syndrome, 3) inconsistency to mobilize appropriate effort during neurocognitive testing noting that the memory and executive function deficits are not consistent with the mild severity of his injury, and 4) adjustment disorder with depressed mood. He recommended a gradual return to work. Dr. Avramov's assessment remained the same, but she added somatic preoccupation. She noted Petitioner indicated he would like to go back to work with restrictions. Dr. Avramov prescribed cognitive-behavior therapy and Lexapro, as suggested by Dr. Barras.

Petitioner has sought further treatment with Dr. McKenzie and Dr. Elkun. Dr. McKenzie diagnosed Post Traumatic Stress Disorder with development of depressive symptoms. Dr. McKenzie's plan was behavioral and cognitive strategies to reduce symptoms. Dr. Elkun notes Petitioner is suffering psychologically, his emotional reaction being the result of his altered cognitive functioning and different personality functioning. He also reports a number of physical symptoms. Dr. Elkun opines that Petitioner is suffering with signs and symptoms consistent with Post Traumatic Brain Injury, with secondary psychological and emotional conditions, being reactions to the effects of that organic injury. The psychological conditions include the diagnoses of Major Depressive Disorder, Anxiety Disorder and Delusional Disorder. Dr. Elkun opined that Petitioner will require on-going neurological intervention, as well as on-going psychiatric intervention.

Respondent has submitted the report of Dr. Thangamani that Petitioner is at MMI with respect to the neck and chest injuries. There is no further treatment recommended for those complaints and the Arbitrator finds that Petitioner sustained injuries to the neck and chest consisting of a cervical sprain and fractured fifth rib which have reached MMI.

With respect to the complaints in the knees, the Petitioner advanced complaints in his knees at the initial emergency room visit. Additional treatment was recommended due to ongoing complaints. Dr. Avramov's recommended referral for further evaluation and treatment for his knees on October 9, 2013. The Arbitrator finds that Petitioner sustained injuries to both knees that have not yet been fully evaluated and are not yet at MMI and are in need for further evaluation and possible treatment per the recommendations of Dr. Avramov.

With respect to the additional symptoms raised to Dr. Avramov, Dr. Barras, Dr. McKenzie and Dr. Elkun, Respondent has offered the reports of Dr. Zelby and Dr. Hartman. After observing Petitioner's testimony and reviewing the exhibits submitted including the medical reports and records, and considering the Petitioner's prior academic and employment record and his multiple requests and efforts to return to work with Respondent, the Arbitrator finds the Petitioner's testimony credible and finds the medical opinions of Dr. Avramov, Dr. McKenzie and Dr. Elkun more persuasive and based upon a more complete and persuasive analysis and explanation of Petitioner's symptoms and conditions.

The Arbitrator does not find the activities documented in the surveillance and Facebook postings as inconsistent with the diagnosis and need for treatment and not inconsistent with Petitioner's testimony that he has had personality changes and has withdrawn from social interaction. Rather, given Petitioner's prior documented drive to succeed and overachieve coupled with the inability to perform tasks demonstrated by his failed attempts to return to work, the investigation is consistent with his attempts to overcome the increasing symptoms of his cognitive deficits and the resulting loss of his self image as a result thereof.

Based upon the record as a whole, including the credible testimony of the Petitioner, the medical records and reports and the additional exhibits submitted, the Arbitrator finds, that as a result of the accidental injuries

sustained on December 17, 2013, the Petitioner has sustained injuries causally connected to the accident as follows:

1. Petitioner sustained a cervical strain and fractured fifth rib which have reached MMI.
2. Petitioner sustained injuries to both knees which have not yet reached MMI and are still in need of further evaluation and treatment.
3. Petitioner sustained injuries as a result of the head injury including Post Traumatic Brain Injury, with secondary psychological and emotional conditions, being reactions to the effects of that organic injury. The psychological conditions include the diagnoses of Major Depressive Disorder, Anxiety Disorder and Delusional Disorder. The conditions of ill being diagnosed by Dr. Avramov, Dr. McKenzie and Dr. Elkun and the treatment recommended for these conditions are causally connected to the accidental injuries sustained on December 17, 2013.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the findings and conclusions contained within Section (F) relating to causal relationship, the Arbitrator finds the treatment by psychologist Dr. Andrew McKenzie and psychiatrist Dr. Leonard Elkun to be reasonable and necessary and causally related to Petitioner's work related injury of December 17, 2013.

Petitioner has also admitted billing from Midwest Imaging Professionals (Px 14), Chicago Imaging (Px 15) and Advocate Trinity Hospital (Px 16) for medical treatment which the Arbitrator finds reasonable, necessary and causally connected to the work related accident sustained on December 17, 2013. To the extent that any of these bills remain outstanding, Respondent shall make payment in accordance with the provisions of Section 8(a) and 8.2 of the Act

The Arbitrator therefore finds that Respondent shall make payment in accordance with the provisions of Section 8(a) and 8.2 of the Act of the following:

Dr. Elkun's	$2,400.00	(Px 17)
Dr. McKenzie balance	$478.00	(Px 18, 19(a))
Chicago Imaging	$150.00	(Px 14)
Midwest Imaging Professionals	$669.00	(Px 15)
Advocate Trinity Hospital	$2,370.00	(Px 16)

Respondent to have credit for any payments made or reductions pursuant to the provisions of Section 8.2 of the Act.

Respondent shall also reimburse Petitioner $194.00 for payments made on Dr. McKenzie's bill (Px 19(b))

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 causal relationship, and the medical records and reports received in evidence, The Arbitrator finds that Petitioner is entitled to prospective medical care as recommended by psychiatrist Dr. Leonard Elkun, psychologist Dr. Andrew McKenzie including the recommended referral to Dr. Bonita Alexander of RIC.

The Arbitrator also finds that Petitioner is entitled to evaluation and treatment for bilateral knee pain by an orthopedic specialist, Dr. Greg Fahrenbach, as recommended by treating neurologist Dr. Avramov on September 17, 2014 and October 9, 2014.

In support of the Arbitrator's decision with respect to (L) Temporary Compensation, the Arbitrator finds as follows:

The parties have stipulated that Petitioner was temporarily totally disabled from December 18, 2013 through March 31, 2014 (14 6/7 weeks) and from June 10, 2014 through October 1, 2014 (16 2/7 weeks).

Based upon the Arbitrator's findings with respect to causal connection including the Arbitrator's finding that the opinions of Dr. McKenzie and Dr. Elkun are more persuasive, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from October 18, 2014 through April 8, 2015, the date of the hearing in this matter.

While Petitioner was released to return to work with restrictions by Dr. McKenzie, the doctor did not place Petitioner at MMI and in fact expressed his reservations as to whether Petitioner could perform the work responsibilities and recommended additional treatment. Respondent did not accommodate the restrictions despite being provided with the physical capacity form. Thereafter, in March 2015, Respondent specifically indicated they were unable to accommodate the restrictions. Dr. Elkun has opined that Petitioner is unable to work. Since Petitioner is still in need of treatment and not at MMI, he is entitled to ongoing temporary compensation either pursuant to *Interstate Scaffolding* or pursuant to the off work opinion of Dr. Elkun and Dr. McKenzie's concerns as to whether Petitioner can perform any work activities without additional treatment.

Based upon the record as a whole, including the Petitioner's testimony, the medical records and reports, and the additional exhibits submitted herein, the Arbitrator finds that Petitioner is entitled to receive temporary total disability benefits for the periods from December 18, 2013 through March 31, 2014, June 10, 2014 through October 1, 2014 and October 18, 2014 through April 8, 2015 (being the date of the hearing) for a total of 55 6/7 weeks. Respondent shall receive credit for benefits paid of **$36,866.52.**

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gustavo Chavez,
Petitioner,
vs.

16IWCC0435

NO: 13 WC 18427

Power Contracting and Engineering,
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, penalties and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 12, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
KWL/vf
O-6/21/16
42

JUN 29 2016

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0435

CHAVEZ, GUSTAVO Case# **13WC018427**

Employee/Petitioner

POWER CONTRACTING AND ENGINEERING

Employer/Respondent

On 5/12/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0786 BRUSTIN & LUNDBLAD LTD
CHARLES E WEBSTER
10 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
BRIAN J KOCH
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0435

Gustavo Chavez
Employee/Petitioner

v.

Power Contracting and Engineering
Employer/Respondent

Case # 13 WC 18427

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **February 26, 2015 and March 20, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 _____

16IWCC0435

FINDINGS

On the date of accident, **February 28, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

In the year preceding the injury, Petitioner earned $**12,395.20**; the average weekly wage was $**1,392.22**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **1** dependent children.

ORDER

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

As Petitioner failed to prove a compensable accident Petitioner's request for attorney's fees and penalties is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Deborah L. Simpson
Signature of Arbitrator

May 11, 2015
Date

ICArbDec19(b)

MAY 12 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gustavo Chavez,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 18427**
	)	
Power Contracting and Engineering,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on February 28, 2013, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that in the year preceding the injuries, the Petitioner earned $12,395.20, and that his average weekly wage was $1,392.22.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries or was he last exposed to an occupational disease that arose out of and in the course of employment; (2) What was the date of the accident; (3) Did the Petitioner give the Respondent timely notice of the accident; (4) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (5) Were the medical services that were provided to the Petitioner reasonable and necessary; and did the Respondent pay all appropriate charges for all reasonable and necessary medical services; (6) Is the Petitioner entitled to prospective medical care; (7) Is Petitioner entitled to TTD; and (8) Should penalties of fees be imposed upon the Respondent.

The Petitioner does not speak English, his native language is Spanish. He testified with the assistance of Alex Gaitan, a certified interpreter, qualified to translate Spanish to English and English to Spanish. Mr. Gaitan testified that he has been qualified and permitted to serve as an interpreter in the Circuit Court of Cook County since 1997, and that he has been qualified and permitted to serve as an interpreter before the IWCC on a number of occasions as well. After being duly qualified and accepted by both parties as an interpreter Mr. Gaitan served as an interpreter for the Petitioner.

STATEMENT OF FACTS

The Petitioner testified that he used to work in construction, and that he was a member of Laborers Union 288. He stated that in February of 2013, and specifically on February 28, 2013 he was employed by the Respondent. According to the Petitioner he worked there for about ten

years prior to being injured at work on February 28, 2013. On that day he was working with a co-worker named Mark. They were putting large sheets of Masonite in a box. According to the Petitioner this was heavy labor, as the sheets were "really long and big." He stated that they were working on that all day, putting panels of Masonite into boxes, and then stacking them. They started doing this at 7:00 a.m. Petitioner testified that the Masonite was heavy, and at the end of the shift, with the last sheets of Masonite Petitioner testified that he felt a strong pain. According to the Petitioner he told Mark about the pain.

At the hearing the Petitioner, pointing with his right hand to his lower back, stated that he felt the pain "right here." He testified that before that pain his back was fine. At this point he stated that when he told Mark about the pain, Mark did not say anything, he was on the other side of the sheet of Masonite, which was about eight feet long, picking it up.

According to the Petitioner, he did not think the injury was serious, so he went home at the end of his shift without reporting the incident to a supervisor. At home he rested, showered and then went to sleep. The pain in his back continued during the night and into the next day. He got up early, at 5:00 a.m., made his coffee, picked up his lunch box and went to work. Petitioner testified that he was limping at the time.

When the Petitioner arrived at work, he saw the foreman whom he identified as David. According to the Petitioner, David asked what was going on with him because he was limping at the time. Petitioner stated that he told David that he had strong pain from the job the day before and that David then told him to take some pills to see if the pain comes down. The Petitioner stated that there was a box in front of David's office with first aid stuff including pills, either Tylenol or Aspirin. Petitioner said that he took some pills, and David watched him do this, and then asked him if he was going to be able to work. The Petitioner said that he told David that he did not know if he could work, then he walked about twenty feet and could not walk anymore because the pain was so great. According to the Petitioner he never had pain like that before.

Petitioner testified that after experiencing the pain trying to walk, he walked back to his truck and went home. He called David on the phone and told him he could not work and was going home. Petitioner stated that he spent the day in bed and on the weekend he started going to doctors.

Petitioner testified that he sought medical treatment at North Shore Medical on March 1, 2013, and that he also sought treatment with Dr. Drake, Dr. Daniel Kuesis and Dr. Bill Smith following the incident of February 28, 2013. Petitioner testified that he provided a history of his accident to each of these providers.

Dr. Smith's medical records document that Petitioner specifically denied any type of work related accident. (PX 6) When confronted with the fact that Petitioner's medical records are devoid of any work related accident, Petitioner testified that the medical records were wrong and that he advised every doctor that he injured himself on February 28, 2013 while working for Respondent. He had no idea why the doctors' records were wrong. He testified that the doctors never showed him their notes and he did not have an opportunity to correct them. However, on cross examination the Petitioner stated twice that he never told anyone that the injury was work

related, nor did he make a written report of the work accident because he was afraid of losing his job.

On cross examination, Petitioner agreed that his Application for Adjustment of Claim was signed by him on June 5, 2013 and that the Application for Adjustment of Claim was also filed on June 5, 2013.

After meeting with an attorney and filing the application, the Petitioner reported to Dr. Drake at Core Orthopedics on June 11, 2013, wherein he provided a history of accident on February 28, 2013 while lifting Masonite for Powers Construction. (PX 8) This is the first medical record that reflects a work injury or knowledge of the Petitioner as to a cause of his pain. When asked with regards to the specificity of his report to Dr. Drake on June 11, 2013 after he met with his attorney, Petitioner testified that he had provided the same history to every provider and they just did not record accurately. Petitioner was then asked why Dr. Drake's medical record of May 14, 2013 suggests that the onset of symptoms was sudden and not related to an injury. Petitioner had no explanation for the apparent discrepancy in histories from Dr. Drake's records.

A review of the medical records of Petitioner, submitted as exhibits at the hearing, show that Petitioner first reported for treatment at North Suburban Family Medicine with a Dr. Tina Blachut on March 1, 2013. Petitioner had a complaint of severe pain in his left thigh gluteus maximus for one day. Dr. Blachut's records indicate that Petitioner's pain was located in the left hip beginning yesterday and happened suddenly. Petitioner's condition has been persisting ever since with pain aching and sharp. Petitioner's associated symptoms included difficulty in ambulation and joint pain but no cramps, joint stiffness, joint swelling, limb pain, muscle spasms, numbness and numbness and tingling of the affected limb. The medical records note, "He could not recall any precipitating event that could have led to the condition." The joint pain is aggravated with bearing weight and he had no similar problem in the past. Petitioner was referred for further treatment with Dr. Drake. (PX 2)

Dr. Drake at Core Orthopedics first examined Petitioner on April 1, 2013. According to Dr. Drake's notes, Petitioner's description of injury was: "three weeks ago he woke up with his left leg not being able to stand or put pressure on it." Dr. Drake's notes continue "the onset of symptoms was sudden and not related to an injury." Dr. Drake, on April 1, 2013 recommended an MRI scan of the lumbar spine pending the results given consideration to an epidural or microdiskectomy. Dr. Drake recommended an MRI of the lumbar spine without contrast. (PX 8)

Dr. Amish Patel, at Premier Pain Specialists first examined Petitioner on April 3, 2013. Petitioner presented as a new patient consultation on April 3, 2013 noting a 56-year-old male presenting with a chief complaint of low back/leg pain with an evaluation and possible treatment recommendation requested. In the April 3, 2013 medical records, Petitioner reported to Dr. Patel the following; "The patient reports that on 3/10/13, he awoke with pain in his low back radiating into his left buttock, lateral thigh, and calf. There was no acute inciting event." (PX 4)

Dr. Patel, as of April 3, 2013, noted that Petitioner had left lumbar radicular mainly involving the left L4 nerve root based upon exam and left L5 nerve root based upon dermatomal distribution. An MRI performed of the lumbar spine without contrast on April 1, 2013 was

reported as a broad based left lateral protrusion into the left lateral recess at L4-5 with superior extension of the disk adjacent to the exiting left nerve root and left foramen. Dr. Patel recommended a left 4-5 transforaminal epidural steroid injection under fluoroscopic guidance. Dr. Patel performed the injection on April 3, 2013. (PX 4)

Petitioner returned on April 18, 2013 for his second injection. On this date, Dr. Patel noted that Petitioner was a 56-year old male with left lumbar radiculopathy mainly involving the left L4 nerve root based on exam and L5 nerve root based upon dermatomal distribution. There is again, no history of work related accident noted in the medical records. (PX 4)

Petitioner also treated with a chiropractor by the name of Bill Smith. Petitioner filed a Laborers Pension Fund and Health and Welfare Claim with chiropractor James Smith signing a document dated May 2, 2013 and signed by Petitioner on May 3, 2013 documenting Petitioner's herniated lumbar disks. With respect to this form, Petitioner was asked if the illness or injury was due to work, response: "no." The form continued: "If you have suffered an injury, was it due to an accident? Response: no." In the portion requesting detailed information of Petitioner's accident the response was listed as non-applicable. This statement was signed by Petitioner on April 11, 2013. (PX 6)

The medical records from Smith Chiropractic also note that Petitioner's pain started on March 1, 2013 and Chiropractor Smith's notes indicate, "Gustavo could not tell one particular incident that caused the pain to start." In the subjective portion of this March 1, 2013 report Chiropractor Smith indicates, "When asked if this was a work related injury, Gustavo said that it was not." (PX 6)

Petitioner treated with Chiropractor Smith again on May 13, 2013, May 15, 2013, May 18, 2013, and May 22, 2013 with no indication of any type of work related component to his back pain. (PX 6)

On May 8, 2013 Petitioner returned to Dr. Patel at Premier Pain Specialists secondary to leg tingling. Petitioner reported that he was post lumbar epidural steroid injection times two with 90% relief of his symptoms. Dr. Patel recorded the fact that Petitioner was able to walk for an hour or more a day and occasionally gets left calf tingling when sitting for longer time but is tolerable. Petitioner reported that he was unable to attend physical therapy but does do exercises at home. Petitioner advised that he was currently taking Ibuprofen 800 milligrams three times a day when necessary. Dr. Patel noted, "patient would like to return to work as he has been off for nine weeks." (PX 4)

In the assessment plan of Dr. Patel dated May 8, 2013, Dr. Patel noted that Petitioner would like to return to work and feels that he would have to miss work for physical therapy. Dr. Patel noted that Petitioner does work construction and therefore will have to lift significant amounts of weight. Dr. Patel suggested a start on light duty with weight restriction of twenty-five pounds and he can do this trial for three weeks and that if he does satisfactory then he would be put back to work full duty. Dr. Patel provided a trial lumbar brace as of May 8, 2013. (PX 4)

On May 14, 2013, Petitioner returned to Dr. Gregory Drake. Petitioner underwent the two epidural injections which offered approximately 50% improvement and he was scheduled for a third injection on May 29, 2013. Petitioner started physical therapy on May 13, 2013 and

he expressed some worry that returning to work in construction would aggravate his condition. Dr. Drake on May 14, 2013 again noted the fact that Petitioner's onset of symptoms was sudden and not related to an injury and the symptoms had been present for approximately four weeks. Dr. Drake, following his examination of Petitioner on May 14, 2013 recommended completion of physical therapy for one month with a return for his third epidural steroid injection and that if this did not provide relief a discectomy should be considered. (PX 8)

Petitioner underwent the third epidural steroid injection with Dr. Patel on May 29, 2013. In the indications of the injection, Petitioner described that following his two injections he had 50% relief but that he had pain in his left low back radiating to his left lower extremity as before. Petitioner indicated that this was worse with lifting anything over twenty-five pounds and that he was examined by Dr. Drake. (PX 4)

Dr. Drake's records on this date note that Petitioner advised that he was not working due to the fact that his work was not able to provide him with light duty restrictions. Petitioner advised that he was not working and that he was attempting to gain work status as he does have an attorney. Dr. Patel noted that Petitioner should continue light duty restrictions as recommended at his last visit. (PX 4)

Petitioner reported to Dr. Drake on June 11, 2013. At this visit, Petitioner's medical history of the pain in his back and leg changed. On June 11, 2013, Petitioner reported to Dr. Drake the following; "He has general concerns about aggravating his condition with retuning to construction. He reports injuring his back on 2/28/2013 when he was lifting Masonite at Powers Construction which caused an increase in his low back pain and left leg pain. On 3/1/2013, he left work due to the intensity of the pain and was seen by his primary care physician."

None of the medical records report that Petitioner described any type of work injury in relation to his medical/physical condition prior to this June 11, 2013 date of treatment.

Dr. Drake noted that Petitioner's leg pain was gone after the injections. Dr. Drake recommended work conditioning to see if a prior level of function could be achieved. Dr. Drake suggested a follow up in four weeks. (PX 8)

On June 12, 2013, Petitioner was also examined by Dr. Patel at which time he advised Dr. Patel that the original inciting event occurred on February 28, 2013 while he was at work while lifting a sheet object weighing approximately thirty pounds repetitively and noted a heat sensation/pain in his low back. That night, he had extreme pain in the low back and tried to go to work the next day. Petitioner did not tolerate working and was sent home. (PX 4)

Petitioner described the fact that he was currently not working due to the fact that his job could not accommodate a light duty restriction. Dr. Patel issued a narrative report indicating that on causality, based upon a reasonable degree of medical and surgical certainty, the patient's condition and associate symptoms were consistent with the reported mechanism of injury and he believes this patient's injuries are causally connected to the injury incident outlined above. (PX 4)

Petitioner also provided a history to Dr. Blair Rhode on November 6, 2014 of an injury sustained on February 28, 2013 while lifting Masonite with a two person lift when he developed severe low back pain with left sided radiation. Petitioner told Dr. Rhode that he performed the

lifting maneuver over and over with progressive symptomology and states that he did not initially report his injury as he thought his symptomology would resolve. He subsequently underwent treatment with Dr. Drake undergoing a series of three injections with relief. An MRI was performed on April 1, 2013 which demonstrated an L4-5 disk with left sided radiation. Petitioner advised that he had worked as a laborer for ten years doing demolition and worked for his employer for ten years with his last day of employment February 28, 2013. Dr. Rhode indicates that Petitioner has low back pain for a work related low back injury sustained on February 28, 2013 while performing a repetitive heavy lift. Petitioner had been managed with epidural steroid injections with relief and continued to be symptomatic and continued to demonstrate radicular complaints. Treatment options were discussed including repeating a series of lumbar epidural injections versus referring the patient for a spine evaluation. Dr. Rhode authorized Petitioner off of work as of November 6, 2014. Petitioner returned to Dr. Rhode on November 20, 2014 for follow up on his low back pain that Dr. Rhode concludes is secondary to an injury while at work. Dr. Rhode again suggested epidural injections and suggested a follow up in two weeks with Petitioner. (PX 13)

On March 20, 2015, Paco Valdarama testified on behalf of the Petitioner. Mr. Valdarama testified that he worked with Petitioner on March 22, 2013. Mr. Valdarama testified that he is a laborer for Power Construction and was working with Petitioner on March 22, 2013. Mr. Valdarama testified that Petitioner complained of back pain at the end of the day and that he finished the clean up job. Mr. Valdarama testified that Mr. Glasson was not present and that he did not observe Petitioner sit down but that he walked slowly. Mr. Valdarama testified that he did not speak to Respondent's counsel before testifying.

Petitioner testified that he continues to suffer from back pain and wishes to pursue medical treatment with Dr. Rhode.

The Respondent called Mr. Dave Glosson to testify on its behalf. With respect to the conversation between Petitioner and Mr. Glosson, Mr. Glosson testified that Petitioner advised him at Power Construction that he was sore in his hip and Mr. Glosson specifically asked him if this was a work related injury and Petitioner said no, that he went home from work yesterday, had dinner and went to bed, when he woke up this morning he had hip pain. Mr. Glosson wrote a narrative report dated March 1, 2013 on the circumstances surrounding this claim of injury.

Troy Schaumleffel was called to testify on behalf of the Respondent as well. He testified that he was a Safety Supervisor for Power Construction. Mr. Schaumleffel testified that Petitioner was off of work for a non-occupational injury when he contacted Mr. Schaumleffel on May 9, 2013 to come back to work. Mr. Schaumleffel testified that as part of the process for returning to work for Power Construction, a worker must pass a physical examination and he instructed Petitioner to report to U.S. Healthworks for an evaluation on his ability to perform full duty work. According to Mr. Schaumleffel, Petitioner did not pass the essential function test and was not eligible to return to work. Mr. Schaumleffel informed Petitioner by way of phone call that he did not get a full duty release to return back to work and therefore he was unable to return to work for Power Construction. Mr. Schaumleffel advised Petitioner that he was unable to come back to work given his restricted work. According to Mr. Schaumleffel, when Petitioner advised Mr. Schaumleffel that he had been off of work for nine weeks, Mr. Schaumleffel stated that unfortunately, this was not a work related injury and therefore not Power Construction's

issue and that once he received a full duty release from his treating physician, he would be able to come back to work. Mr. Schaumleffel testified that Petitioner never provided a history of accident to him even through the date of the hearing on February 26, 2015.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission,* 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

To be compensable under the Act, the injury complained of must be one "arising out of and in the course of the employment". *820 ILCS 305/2*(West 1998). An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment, involving a causal connection between the employment and the accidental injury. *Parro v. Industrial Comm'n,* (1995) 167 Ill. 2d 385,393, 212 Ill. Dec. 537, 657 N.E. 2d 882.

Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission*, 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission*, 52 Ill. 2d 490 (1972

The courts presume that when a person seeks treatment for an injury, he will not falsify statements to a physician from whom he expects to receive medical aid. *Shell Oil Co. v. Industrial Comm'n,* 2 Ill.2d 590, 592 119 N.E. 2d 224, 226 (1954).

Section 6(c) of the Illinois Workers' Compensation Act states that notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident. Section 6(c) (2) states that "[n]o defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy." *820 ILCS 305/6(c)* (West 2004)

The purpose of the notice provisions is to enable the employer to investigate promptly and to ascertain the facts of the alleged accident. *City of Rockford v. Industrial Commission,* 214 N.E.2d 763 (1966) The giving of notice under the Act is jurisdictional and a prerequisite of the right to maintain a proceeding under the Act. However, the legislature has mandated a liberal construction on the issue of notice. *S&H Floor Covering v. The Workers Compensation Commission,* 870 N.E.2d 821 (2007)

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the evidence at trial does not support the Petitioner's claim of an accidental injury that arose out of and in the course of his employment. The Petitioner's testimony was not credible. Petitioner testified at trial that he felt immediate pain to his back on February 28, 2013 and that he advised Respondent of the injury on March 1, 2013. The Arbitrator notes that this is entirely inconsistent with the histories contained in the Petitioner's medical records and the testimony of two witnesses from Respondent, Power Construction as well as being a contradiction of his testimony on cross examination.

Petitioner's medical records note treatment with Chiropractor Bill Smith, North Suburban Family Medicine, and Dr. Gregory Drake at Core Orthopedics. In multiple visits with these providers, Petitioner never provided a history of a work accident. In several instances in the medical records, Petitioner specifically denied that he was injured at work. Like the court in *Shell Oil v. Industrial Commission*, this Arbitrator also presumes that when a person seeks treatment for an injury, he will not falsify statements to a physician from whom he expects to receive medical aid.

The Petitioner admitted twice on cross examination that he did not report to anyone that he was injured at work. On one of those occasions he stated that he did not tell anyone it was work related because he was afraid of losing his job.

Mr. Glosson testified that Petitioner never advised him of a work accident and that Petitioner specifically denied a work accident when Mr. Glosson asked Petitioner whether he was injured at work. Petitioner's contemporaneous medical records are consistent with Mr. Glosson's testimony in that Petitioner denied any work accident in the medical records as he did with Mr. Glosson.

Mr. Schaumleffel testified that he was aware that Petitioner had been off of work for personal reasons and that Petitioner approached him about returning to work for Respondent in May of 2013. Mr. Schaumleffel testified that in order to return to work, Petitioner had to be cleared for return to work. Mr. Schaumleffel testified that Petitioner was sent to US Healthworks for a return to work evaluation. When Mr. Chavez was not cleared for full duty work, Mr. Schaumleffel advised Petitioner that Respondent could not bring Petitioner back to work until he was cleared by his doctor. Mr. Schaumleffel testified that Petitioner complained that he needed to return to work and that he had been off of work for 9 weeks. Mr. Schaumleffel testified that Petitioner never advised him of any work incident.

The Arbitrator further notes that there are numerous inconsistencies between Petitioner's testimony and his medical records. According to the medical records submitted as exhibits, Petitioner first reported for treatment at North Suburban Family Medicine with a Dr. Tina Blachut on March 1, 2013. On this date of treatment, the medical records note, "He could not recall any precipitating event that could have led to the condition." Mr. Chavez was referred for

further treatment with Dr. Drake.

Dr. Drake at Core Orthopedics first examined Petitioner on April 1, 2013. According to Dr. Drake's notes, Petitioner's description of injury: "Three weeks ago he woke up with his left leg not being able to stand or put pressure on it." Dr. Drake's notes continue "the onset of symptoms was sudden and not related to an injury."

Dr. Amish Patel, at Premier Pain Specialists first examined Petitioner on April 3, 2013. Petitioner presented as a new patient consultation on April 3, 2013 noting a 56-year-old male presenting with a chief complaint of low back/leg pain with an evaluation and possible treatment recommendation requested. In the April 3, 2013 medical records, Petitioner reported to Dr. Patel the following; "The patient reports that on 3/10/13, he awoke with pain in his low back radiating into his left buttock, lateral thigh, and calf. There was no acute inciting event."

Petitioner also treated with a chiropractor by the name of Bill Smith. Petitioner filed for a Laborers Pension Fund and Health and Welfare Claim with chiropractor James Smith signing a document dated May 2, 2013 and signed by Petitioner on May 3, 2013 documenting Petitioner's herniated lumbar disks. According to this form, Petitioner was asked if the illness or injury was due to work, response: "no." The form continued: "If you have suffered an injury, was it due to an accident? Response: no." Petitioner's detailed information with regards to accident was listed as non-applicable. This was a statement signed by Petitioner on April 11, 2013.

The subpoenaed medical records from Smith Chiropractic also note that Petitioner's pain started on March 1, 2013 and Chiropractor Smith's notes indicate, "Gustavo could not tell one particular incident that caused the pain to start." In the subjective portion of this March 1, 2013 report Chiropractor Smith indicates, "When asked if this was a work related injury, Gustavo said that it was not."

The Arbitrator notes that the medical history changed when Petitioner reported to Dr. Drake on June 11, 2013, after having met with his lawyer and having signed and filed a Request for Adjudication of a Claim. Petitioner reported to Dr. Drake the following; "He has general concerns about aggravating his condition with retuning to construction. He reports injuring his back on 2/28/2013 when he was lifting Masonite at Powers Construction which caused an increase in his low back pain and left leg pain.

Petitioner never described any type of work injury in his medical treatment prior to this June 11, 2013 date of treatment. The Arbitrator cannot reconcile the numerous references in the medical records that document that Petitioner repeatedly denied a work accident with this suddenly detailed claim of accident. The Petitioner has failed to prove by a preponderance of the evidence that he suffered an accidental injury that arose out of and in the course of his employment on February 28, 2013.

What was the date of the accident? Did the Petitioner give the Respondent timely notice of the accident? Is the Petitioner's current condition of ill-being causally connected to this injury or exposure? Were the medical services that were provided to the Petitioner

reasonable and necessary? Did the Respondent pay all appropriate charges for all reasonable and necessary medical services? Is the Petitioner entitled to prospective medical care? Is Petitioner entitled to TTD? Should penalties of fees be imposed upon the Respondent?

The Arbitrator specifically incorporates and restates her findings regarding whether Petitioner sustained accidental injuries that arose out of and in the course of his employment, above, into this section regarding the remaining issues at the hearing. The Petitioner has failed to prove a compensable accident pursuant to the Act. The above listed issues are moot.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

The Petitioner failed to prove a compensable accident therefore Petitioner's request for attorney's fees and penalties is denied.

Deborah L. Simpson
Signature of Arbitrator

May 11, 2015
Date

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

Cynthia Fink ,
Petitioner,
vs.

NO: 14WC 27208

Illinois Veterans' Home ,
Respondent,

16IWCC0436

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, 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 November 17, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $55,100.00. 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:
o060916
DLG/mw
045

JUN 29 2016

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

FINK, CYNTHIA
Employee/Petitioner

Case# **14WC027208**

ILLINOIS VETERANS' HOME
Employer/Respondent

16IWCC0436

On 11/17/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0293 KATZ FRIEDMAN EAGLE ET AL
PHILIP A BARECK
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

NOV 17 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0436

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

Cynthia Fink
Employee/Petitioner

v.

Illinois Veterans['] Home
Employer/Respondent

Case # 14 WC 27208

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 Quincy, on October 7, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On May 7, 2013, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $47,824.97; the average weekly wage was $919.71.

On the date of accident, Petitioner was 29 years of age, married with 2 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $17,204.26 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $17,204.26.

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 $613.14 per week for 31 1/7 weeks commencing May 15, 2013, through December 18, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $551.83 per week for 65 weeks because the injuries sustained caused the 13% loss of use of the person as whole, as provided in Section 8(d)2 of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator

November 16, 2015
Date

NOV 17 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on May 7, 2013. According to the Application, Petitioner was "Injured at work" and sustained an injury to the "Right shoulder cervical, and body" (Arbitrator's Exhibit 2). The Application did not allege this to be a repetitive trauma injury; however, the evidence in this case clearly indicated that this was the basis for this claim. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in December, 2011, as a Certified Nursing Assistant (CNA). Petitioner's job duties consisted of caring for the patients and included such things as bathing them, helping them get dressed, go to the bathroom, etc. Petitioner testified that the job was very physically demanding and required her to do a significant amount of lifting of patients to move them from one location to another. Petitioner stated that she would generally spend two to three hours of each work day transferring patients from one place to another. On May 7, 2013, Petitioner stated that she spent approximately four to five hours transferring patients. One significant factor that made Petitioner's job even more difficult on that day was the fact that she worked with a significant number of patients who had Alzheimer's and they would many times be combative or non-cooperative.

On May 7, 2013, Petitioner was moving a patient who she estimated weighed around 200 pounds and she sustained what she described as a pressure/discomfort in her right shoulder. Prior to that time, Petitioner had experienced some aches in her right shoulder, but she did not seek any medical treatment. Petitioner was able to complete her shift on May 7; however, the following morning the pain intensified and she went to the ER of Blessing Hospital.

According to the ER record of May 8, 2013, Petitioner had pain in her right shoulder for the preceding six months, but more for the last seven days because she had been using her right arm more. Petitioner also complained of pain shooting down her arm and making her hand numb (Petitioner's Exhibit 5).

Petitioner was again seen at the ER of Blessing Hospital on May 16, 2013. At that time, Petitioner again complained of right arm pain for the preceding six months which was worse recently. Petitioner also had symptoms of numbness/tingling in her right hand. The initial clinical impression was a possible right biceps tendon rupture (Petitioner's Exhibit 5).

On May 24, 2013, Petitioner completed and signed an Employee's Notice of Injury form which stated that Petitioner injured her right shoulder on May 7, 2013, while transferring and lifting patients and that it occurred while she was pulling, tugging and lifting patients (Petitioner's Exhibit 1). On that same day, a Veterans' Home Incident Report was prepared which noted that on May 7, 2013, Petitioner was lifting and transferring residents and, on the following day, her right arm was painful and she went to the ER (Petitioner's Exhibit 1).

An Employer's First Report of Injury was also prepared on May 24, 2013, which stated that Petitioner sustained an upper arm injury on May 7, 2013, because of repetitive motion. A

Supervisor's Report of Injury was prepared on June 4, 2013, which stated that, on May 7, 2013, Petitioner had worked lifting and transferring residents and that her right shoulder was hurting the following day. The report also noted Petitioner's various regular job duties (Petitioner's Exhibit 1).

On May 24, 2013, Petitioner was seen by Dr. Jawad Saade, her family physician. At that time, Petitioner informed Dr. Saade that she had pain in her right shoulder "off/on" for the past six months. She also told Dr. Saade that she had been working a lot of 16 hour shifts and that she had a pain level of 8/10. Dr. Saade opined that Petitioner had right shoulder pain and ordered physical therapy. She was to be seen by him again in six weeks (Petitioner's Exhibit 2).

At the direction of the Respondent, Petitioner was subsequently seen by Dr. Joseph Kim. Dr. Kim initially saw Petitioner on May 28, 2013, and noted that Petitioner complained of right arm pain going from her shoulder to her fingers with associated numbness. He noted that Petitioner worked as a CNA and transferred patients (Petitioner's Exhibit 3).

Petitioner was again seen by Dr. Kim on June 7, 2013. According to Dr. Kim's record of that date, he evaluated Petitioner for a "work related injury" when she did excessive lifting on May 7 and began to experience right arm/hand symptoms the following day. Dr. Kim specifically noted that Petitioner's symptoms were "...caused by an injury." Dr. Kim ordered an MRI of both the right shoulder and cervical spine (Petitioner's Exhibit 3).

The MRIs were performed on June 20, 2013. The MRI of the cervical spine did not reveal any significant findings. The MRI of the right shoulder revealed mild acromioclavicular osteoarthritis, tendinopathy and possible labral tears (Petitioner's Exhibit 5).

Dr. Kim saw Petitioner on June 28, 2013, and reviewed the MRI scans. He opined that the MRI of the right shoulder revealed a labral tear but that the rotator cuff was intact. Dr. Kim ordered physical therapy and medication. He again described the condition as being work-related (Petitioner's Exhibit 3).

Dr. Kim again saw Petitioner on July 30, 2013, and Petitioner's right shoulder, arm and hand symptoms were unchanged. Dr. Kim again noted that this was a work injury. He recommended Petitioner have an EMG and that she be seen by an orthopedic specialist (Petitioner's Exhibit 3).

On August 15, 2013, Petitioner was seen by Dr. David Bingham, an orthopedic surgeon. At that time, Petitioner informed Dr. Bingham that she had worked for Respondent in the Alzheimer's ward and had to do a lot of heavy lifting and carrying. In regard to May 7, Petitioner informed Dr. Bingham that she did not recall a specific incident but had sharp pain in her right shoulder the following day. Dr. Bingham examined Petitioner and reviewed the MRIs of both the cervical spine and right shoulder. He opined that the right shoulder MRI was fairly benign. He diagnosed Petitioner with rotator cuff syndrome and performed an injection (Petitioner's Exhibit 4).

Petitioner was seen by Dr. Kim and Dr. Bingham on August 30, and September 5, 2013, respectively. On both occasions it was noted that Petitioner's condition was worsening. Dr.

Bingham referred Petitioner to Dr. Adam Derhake, an orthopedic surgeon associated with him (Petitioner's Exhibits 3 and 4).

Dr. Derhake initially evaluated Petitioner on September 16, 2013. At that time, Petitioner informed Dr. Derhake that, in May, she had done a lot of lifting of patients and, the following day, had severe right shoulder/arm pain. Dr. Derhake noted Petitioner had received four to five months of conservative treatment but had no long-term relief. Dr. Derhake reviewed both MRIs. In regard to the right shoulder MRI, he opined that it did not reveal any rotator cuff or labral tears; however, he recommended Petitioner have an arthroscopic surgery on the right shoulder for a subacromial decompression, possible rotator cuff repair and possible biceps tenotomy (Petitioner's Exhibit 4).

Dr. Derhake performed arthroscopic surgery on Petitioner's right shoulder on October 17, 2013. The procedure consisted of a subacromial decompression with bursectomy and debridement of the distal supraspinatus tendon (Petitioner's Exhibit 5).

Following surgery, Petitioner continued to be seen by Dr. Derhake. When seen in November and December, 2013, Petitioner still had right shoulder symptoms but her condition had improved. Dr. Derhake anticipated Petitioner could return to work without restrictions in approximately one month, but recommended a functional evaluation at that time (Petitioner's Exhibit 4).

Petitioner testified that she was off work from May 15, 2013, through December 18, 2013, and that she returned to work on December 19, 2013 with restrictions. At trial, counsel for Petitioner and Respondent stipulated that Petitioner was temporarily totally disabled for the aforestated period of time.

Petitioner stated that after she returned to work, she continued to have right shoulder problems. Petitioner was seen by Dr. Derhake on January 8, 2014. At that time, Petitioner informed Dr. Derhake that her right shoulder symptoms/pain had worsened since she returned to work. Petitioner also advised that Respondent had not been compliant with her work restrictions. On examination, Dr. Derhake noted that there were no objective findings and that Petitioner's pain was out of proportion of what he expected it to be. However, Dr. Derhake continued to impose restrictions and ordered a functional capacity evaluation (FCE) (Petitioner's Exhibit 4).

An FCE was performed on January 28, 2014. According to the examiner, Petitioner provided a "Valid Effort" and was limited to the "Medium demand vocation." According to the FCE, Petitioner was not able to lift more than 20 pounds repetitively or push/pull clients (in a wheelchair) that weighed more than 240 pounds. Petitioner was able to perform repetitive forward reaching, bend, twist, stoop, walk, sit, stand and exercise fine motor and gross dexterity. (Petitioner's Exhibit 4).

Petitioner was seen by Dr. Derhake on February 7, 2014, and he reviewed the FCE. At that time, Dr. Derhake opined that Petitioner was at MMI and he imposed permanent work restrictions consistent with the FCE (Petitioner's Exhibit 4).

Petitioner was subsequently seen by Dr. Kim on February 19, 2014. At that time, Dr. Kim noted that Petitioner was taking large amounts of narcotics and that she needed to be weaned off of them. He had the Petitioner sign a "narcotic agreement" on that date. On examination, the range of motion of the right shoulder was full and there was no weakness of the rotator cuff (Petitioner's Exhibit 3).

Petitioner was seen by Dr. Kim on March 19, 2014. At that time, Petitioner was tested for narcotics and there was no evidence of same. Petitioner continued to complain of right shoulder pain especially after completing a 12 hour shift (Petitioner's Exhibit 3).

Petitioner returned to Dr. Kim on April 18, 2014, because of her continued right shoulder pain. Dr. Kim gave Petitioner a trigger point injection and imposed work restrictions for one month (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Luke Choi, an orthopedic surgeon, on February 2, 2015. The primary purpose of this examination was to obtain an AMA impairment rating. Dr. Choi reviewed medical records and the MRI scans in connection with his examination of Petitioner. Dr. Choi's report specifically noted that Petitioner developed shoulder pain after transferring and lifting patients on May 7, 2013. Dr. Choi's findings on examination were benign and he opined that Petitioner exhibited both "symptom magnification" and a "poor effort" during the examination. He opined that Petitioner had a one percent (1%) permanent partial impairment of the right upper extremity at the level of the shoulder which resulted in a one percent (1%) whole person impairment (Respondent's Exhibit 2).

Dr. Choi was deposed on August 5, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Choi's testimony was consistent with his report and he reaffirmed the opinions contained therein (Respondent's Exhibit 1; pp 6-12).

On cross-examination, Dr. Choi agreed that he was not certified to do impairment ratings. When asked to define the AMA definition of "impairment," Dr. Choi stated "I don't feel comfortable giving a very clear definition without looking at it again." When asked if an individual could have a low impairment but yet a high disability, Dr. Choi stated: "I do not know that." (Respondent's Exhibit 1; p 12, 16).

Dr. Choi did not include a quickdash, nor did he have the Petitioner complete a quickdash at the time of the examination. He also agreed that he mislabeled the table he used when he determined the impairment rating (Table 16.2 regarding foot/ankle injuries instead of Table 15.2 for upper extremity injuries). He also agreed that he based his impairment rating on the diagnosis of shoulder impingement and not a rotator cuff tear and that if there was more than one way to rate an impairment, the AMA guidelines required that the method that produced the higher rating be used (Respondent's Exhibit 1; pp 17-19).

At trial, Petitioner testified that she continued to work as a CNA for Respondent until early October, 2015, just shortly before this case was tried. Petitioner stated that she received help at work when performing tasks that exceeded her restrictions. Petitioner stated that her right shoulder pain was, at times, "unbearable." Petitioner made the decision to go back to school to be

trained as a radiology and medical office assistant as this work would be much less strenuous. At the time of trial, Petitioner was attending John Woods Community College.

Petitioner testified that she is right hand dominant and she has difficulty reaching high shelves because of her shoulder pain. Petitioner's right shoulder continues to "pop" and she still experiences pain and a pressure type sensation in her right shoulder.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained a repetitive trauma injury to her right shoulder and cervical spine arising out of and in the course of her employment for Respondent that manifested itself on May 7, 2013.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony that she generally spent two to three hours per day lifting/transferring patients, but that on May 7, 2013, she spent four to five hours lifting/transferring patients, was unrebutted.

Petitioner's testimony that she experienced an ache in her shoulder on May 7, 2013, and that it had considerably worsened by the following morning was unrebutted and was consistent with the medical records of all of the medical providers.

Petitioner's treating physicians, Dr. Kim (who she saw at Respondent's direction), Dr. Bingham, and Dr. Derhake, as well as Respondent's Section 12 examiner, Dr. Choi, all noted that Petitioner's right shoulder condition was work-related.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner is entitled to temporary total disability benefits of 31 1/7 weeks commencing May 15, 2013, through December 18, 2013.

In support of this conclusion the Arbitrator notes the following:

At trial, counsel for Petitioner and Respondent stipulated that Petitioner was temporarily totally disabled for the aforestated period of time.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 13% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Dr. Choi opined that there was an AMA impairment rating of one percent (1%) of the whole person. The Arbitrator is not certain if this is, in fact, a valid AMA impairment rating because Dr. Choi agreed he is not certified to perform such ratings. Dr. Choi was unable to give a definition of the AMA definition of impairment. His report referenced the incorrect table. Dr. Choi did not include a quickdash. Also, he may not have rated the impairment in accordance with a rotator cuff tear/injury. The Arbitrator gives this fact this minimal weight because of the uncertainty of the validity of the rating.

At the time of the manifestation, Petitioner was a CNA, a job that required a significant amount of lifting/transferring patients. While Petitioner was able to return to work to her regular job, she continued to have shoulder symptoms to the extent that she made the decision to return to school to seek a less physically demanding job. The Arbitrator gives this factor moderate weight.

Petitioner was 29 years of age at the time of manifestation. She will have to live with the effects of this injury for the remainder of her working and natural life. The Arbitrator gives us factor significant weight.

Petitioner made the decision to return to school to allow her to seek other employment that would be less physically demanding. It is uncertain what Petitioner's future earning capacity will be. There was no evidence as to whether the injury will have any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

Petitioner sustained an injury to her right shoulder which required arthroscopic surgery that consisted of a subacromial decompression with bursectomy and debridement of the distal supraspinatus tendon. An FCE was performed and Petitioner was subject to permanent work restrictions imposed by her treating physician. The Arbitrator gives us factor significant weight.

William R. Gallagher, Arbitrator

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

Arlonya C. Paulette,

Petitioner,

vs.

NO: 11WC 23719

16IWCC0437

The R E M Group Inc,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 9, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

PAULETTE, ARLONYA C
Employee/Petitioner

Case# 11WC023719

16IWCC0437

THE R E M GROUP INC
Employer/Respondent

On 9/9/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2424 SAUTER SULLIVAN & EVANS
CHRISTOPHER K GELDMACHER
3415 HAMPTON AVE
ST LOUIS, MO 63139

0000 RUSIN & MACIOROWSKI LTD
SARAH TRIPP
231 W MAIN ST SUITE 2E
CARBONDALE, IL 62901

16IWCC0437

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Arlonya C. Paulette
Employee/Petitioner

v.

The R.E.M. Group, Inc.
Employer/Respondent

Case # 11 WC 23719

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 **Collinsville**, on **July 22, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **March 31, 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 that date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of the accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident on March 5, 2013

In the year preceding the injury, Petitioner earned $**less than two weeks**; the average weekly wage was $**$405.00**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **3** dependent children.

Petitioner has received all reasonable and necessary medical services

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$3,240.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $**$3,240.00**.

Respondent is entitled to a credit of **$0.00** for medical bills paid by its group medical plan for which credit is allowed under Section 8(j) for medical bills paid by its group medical plan.

ORDER

Petitioner failed to prove a causal connection between her current condition of ill-being and her accident of March 31, 2011. Petitioner reached maximum medical improvement as a result of her work-related accident on September 17, 2013, and has failed to prove ongoing causation thereafter.

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

September 4, 2015
Date

SEP 9 - 2015

Arlonya Paulette v. The R.E.M. Group, Inc. IWCC No.: 11-WC-23719

FINDINGS OF FACT and CONCLUSIONS OF LAW

This case was previously tried on a 19(b) Petition before Arbitrator Granada on March 28, 2012, with an appeal following to the Commission. A decision was issued by the Commission on March 28, 2013 affirming and adopting the Arbitrator's Decision.

At the time of the current arbitration hearing, the disputed issued included causal connection, temporary total disability benefits, medical bills, and prospective medical care. Stephanie Escalet was present on behalf of Respondent during the hearing.

The Arbitrator Finds:

Petitioner sustained an undisputed accident while working for Respondent on March 31, 2011. Respondent, a temporary placement agency, had assigned Petitioner to work at Berkley Construction picking and packaging boxes on an assembly line. While working on the production line, Petitioner was stuck by a cage that fell off a nearby forklift. Petitioner described immediate pain in her neck, low back, upper back, shoulder and arm. (PX 1, 2)

After the accident, Petitioner was referred by her employer to the Occupational Clinic which, in turn, referred Petitioner to Dr. Brett Taylor. Dr. Taylor ordered an MRI and initiated a treatment plan for Petitioner comprised of chiropractic care, physical therapy and an injection to the lumbar and cervical spine. (PX 1, 2) Following the first set of injections, Dr. Taylor recommended that Petitioner continue conservative treatment at the direction of Dr. Boutwell to include physical therapy and injections. (PX 1, 2)

At the request of Respondent, Petitioner was seen for Section 12 examinations with Dr. David Robson on July 21, 2011 and November 16, 2011. During both examinations, Dr. Robson noted that Petitioner reported high levels of pain that were not supported by objective findings. As of November 16, 2011, Dr. Robson felt that Petitioner has reached maximum medical improvement (MMI) from the work injury and was not in need of any additional treatment. (PX 1, 2)

As the parties had reached an impasse regarding Petitioner's care and treatment, her claim proceeded to arbitration on March 28, 2012 pursuant to a Section 19(b) Petition filed by Petitioner. Petitioner testified that she was injured on March 31, 2011 while working for Respondent at Berkeley Construction. Petitioner was putting product into boxes which required her to remove the product from the assembly line and place it down into the boxes. While doing so Petitioner felt a "jerk" when a gentleman driving a forklift, with a "cage" in front, was tilted onto her back and it made her fall over. The line was immediately stopped and Petitioner went to speak with her supervisor. Petitioner testified that the cage knocked her forward into the conveyor belt and she immediately felt a lot of pain in her neck, lower back, upper neck, shoulder, and arm. Petitioner proceeded to seek treatment as outlined above. At the time of the first 19(b) hearing, Petitioner complained of neck pain described as "8/10" and low back pain of "7/10." Petitioner testified that her pain would come and go. She also described a shooting pain

in her right arm and right leg pain that began right after the accident. Petitioner denied ever going to Touchette Hospital for back pain or an injured right arm and wrist. She denied going to physical therapy for low back pain in 1997. She requested authorization of additional injections and physical therapy as recommended by Dr. Taylor. (PX 1)

The Arbitrator issued his Decision on May 29, 2012, finding in favor of Petitioner and awarding her prospective medical care as recommended by Dr. Taylor, along with medical bills and temporary total disability benefits. In his Decision, the Arbitrator found causation in Petitioner's favor noting the persuasive opinion of Dr. Taylor over that of Dr. Robson. He further noted that Dr. Robson even opined that Petitioner's accident aggravated some of Petitioner's presumed pre-existing conditions and, as such, his causation opinion "outweigh[ed] his observation that Petitioner's subjective complaints are not supported by the objective findings." He further noted that while Respondent brought out inconsistencies in Petitioner's testimony regarding her past medical care and her attempts to return to work, those "subtle inconsistencies" were not fatal to Petitioner regarding the issue of causation. (PX 2, p. 5) In a Decision entered by the Commission on March 28, 2013 the Arbitrator's Decision was affirmed in its entirety. (PX 2, 3)

On May 22, 2013 Petitioner returned to see Dr. Taylor for re-evaluation of her neck and low back. Petitioner described ongoing right paracervical muscle spasms and stabbing pain which gave her significant cervicogenic and temporal headaches. She also reported intermittent pain midline directly over her cervical spine. Petitioner described 50% neck pain and 50% arm pain on the right especially with raising her arm and moving her neck. Petitioner also had some right shoulder weakness and numbness throughout the right arm. Petitioner reported difficulty picking up small objects. Petitioner also reported numbness in her right foot but no other left lower extremity symptoms. She also complained of intermittent midline low back pain. Sitting, standing and walking were difficult. Dr. Taylor noted that Petitioner was a suitable candidate for surgery but she preferred to try non-operative treatments. (PX 7)

Petitioner resumed treatment with Dr. Boutwell on June 5, 2013. Petitioner reported that she received exceptional responses to the epidural injections previously provided at the C4-5 and L5-S1 levels. Since that time she had enjoyed nearly complete resolution of her symptoms that, of late, had become "atraumatically recurrent." Petitioner reported that her current complaints were "exactly the same, just more intense" than they were when she first began treating in 2011. (PX 8) Dr. Boutwell did not feel that additional imaging or diagnostic testing was necessary in light of the fact Petitioner's symptoms appeared to be identical to those she presented with in 2011.
On examination of the cervical spine, Dr. Boutwell noted some minor right torticollis, no significant muscle spasm or trigger points, no tenderness, normal limits in all myotomes and dermatomes with the exception of some mildly decreased sensation in the right C6 dermatome. Examination of the low back revealed range of motion to be within normal limits, no tenderness to palpation of the midline and paraspinal areas, no significant muscle spasms, and negative straight leg raise bilaterally. Dr. Boutwell recommended epidural injections at C4-5 and L5-S1 and 6 visits of aquatic therapy. She prescribed Naproxen and Ultracet for breakthrough pain. Dr. Boutwell recommended a follow-up in four months. She anticipated that Petitioner would be significantly improved at that time and would likely be returned to full duty status.
(PX 8)

On July 1, 2013, Petitioner underwent a C4-5 epidural steroid injection, L5-S1 epidural steroid injection, and a right L4-5 transforaminal epidural space injection. The injections were repeated on July 15, 2013. (PX 9)

On July 22, 2013 Petitioner accepted Respondent's modified duty assignment which was offered based upon a "recent medical report received from Dr. Knapp at Gateway Occupational Health Clinic." (RX 18) Petitioner was advised that the assignment (General Laborer with miscellaneous duties to include filing, light cleaning up, etc.) was within her capabilities and restrictions and she would only be assigned tasks consistent with her physical abilities. Petitioner was to work Monday through Friday from 9:00 a.m. to 1:00 p.m. (RX 18)

Petitioner returned to Dr. Boutwell on July 23, 2013, and reported that she continued to enjoy improvement secondary to the therapies. Petitioner reported that the aquatic physical therapy dramatically improved her mobility and discomfort in her cervical spine. She reported that she was still having some discomfort in her right low back and hip which was improved but limited her ability to lift and ambulate. She reported her discomfort ranged from 8/10 to 10/10 in intensity. She also described an aching sensation down her right shoulder and arm, down the right side of her body into the right leg. On exam, Petitioner no longer had torticollis of the cervical spine. She did appear to have some difficulty standing only on her right foot secondary to a complaint of discomfort in the right hip with some subjective report of weakness. Examination of the cervical and lumbar spines was essentially normal. Because Petitioner was reporting a significant improvement of her symptoms with her current pharmacotherapy and in light of her recent physical therapy, Dr. Boutwell felt Petitioner might be appropriate for placement at maximum medical improvement (MMI) without a surgical referral. Dr. Boutwell felt that Petitioner could resume activities of no lifting greater than 40 pounds, repetitively lifting no more than 20 pounds, and pushing and pulling no greater than 100 pounds unless on a wheeled cart. She also felt Petitioner might prevent future injury and sustain her work long term if she could alternate between sitting and standing. Petitioner was to follow-up in two weeks for anticipated MMI release. (PX 8)

Petitioner returned to Dr. Boutwell on August 6, 2013. Dr. Boutwell felt no further treatment was indicated and released Petitioner at MMI. Dr. Boutwell did not feel that Petitioner was a surgical candidate based on her current level of function and quality of life, and recommended continued use of medications as needed. Petitioner reported occasional weakness and discomfort in her back and legs. She described subjective discomfort ranging from 7-10/10 especially worse with sitting and standing too long or walking. No additional physical therapy was deemed necessary as Petitioner was doing a home exercise program. Dr. Boutwell felt the prescribed medications would be reasonably necessary for the next six months. She provided Petitioner with permanent restrictions of no lifting greater than 30 pounds, the ability to alternate between sitting and standing as needed, and no repetitive lifting more than 20 pounds. The restrictions were noted to apply to a forty hour work week. Petitioner was to continue with her home exercise program also. Petitioner's prescriptions were reviewed and adjusted with refills being provided. Dr. Boutwell felt the medications might be necessary for an additional six months. (PX 8)

Petitioner returned to see Dr. Taylor on September 17, 2013 reporting ongoing neck and arm pain as well as 100% back pain. Petitioner's symptoms were essentially unchanged since her last

exam. Petitioner's neck pain was reportedly "fairly severe" at the time of the visit and she reported it was painful to look after herself but she was slow and careful. Petitioner reported frequent headaches of a moderate nature. She felt she could not do her usual work. Her neck disability index score was improved. With regard to her back, Petitioner reported that pain prevented her from sitting more than one-half an hour and she could not sleep more than four hours per night. Surgery was again discussed but Petitioner was not ready to proceed with it. Dr/ Taylor saw no evidence of somatization or malingering. He agreed with Dr. Boutwell['s restrictions of light duty and lifting. (PX 7)

Petitioner was seen in the emergency room at Touchette Regional Hospital on September 20, 2013, with complaints of pain to her arms, shoulders, neck and back following a motor vehicle accident 2 days prior. According to notes, Petitioner was the restrained driver and her car was rear-ended but the airbag did not deploy. Petitioner was able to move all of her extremities without difficulty. Petitioner's primary complaints were regarding her ribs and right hip. She denied any loss of consciousness, back pain or neck pain. According to the Triage Note, Petitioner denied any disability and reported being independent in her activities of daily living. Petitioner was diagnosed with muscle spasms and provided with prescriptions for Flexeril and Norco. (RX 16)

On October 4, 2013, Petitioner presented to PA Sarah Rahman at SIHF Cahokia Health Center for an ER follow-up visit after her motor vehicle accident on September 18, 2013. Petitioner reported aching pain radiating to her back. She reported that she tried to take a muscle relaxer to help her pain but it made her sleepy. Petitioner reported that her neck pain was aggravated by lifting and movement. On exam, tenderness and mild pain with motion was noted in the cervical and lumbar spine. Petitioner was referred to physical therapy and provided with Robaxim and Naproxen to take twice daily. She was to follow-up in four weeks. Petitioner was told she was "ok" to return to work. (RX 17)

Petitioner then presented to the physical therapy department at Touchette Regional Hospital on October 16, 2013. She reported complaints of neck and back pain that began on September 8, 2013. She described the pain as tingling and aching and that moving made her pain worse. She reported that "everything" was difficult for her to do because of this injury. She denied the injury as being work-related and claimed she had undergone no treatment for this injury. The therapist noted a history of neck pain for three years but that Petitioner had been in a motor vehicle accident on September 8, 2013 with increasing neck pain. She described her occupation as "office work." She denied any other significant medical conditions. Petitioner cancelled her appointment for the 21st. Petitioner was seen for physical therapy again on October 24, 2013, failed to appear on October 31st, and was discharged on November 1, 2013 for failure to return for further visits. (RX 16)

Petitioner was late for work on November 15, 18, 19, 20, and 21, 2013. (RX 18)

Petitioner presented to the emergency room at Touchette Regional Hospital on November 22, 2013, with complaints of right flank pain that began one day earlier when she lifted a heavy sign at work. The assessment was right flank pain and probable lumbar radiculopathy. Petitioner was provided with prescriptions for Flexeril and Motrin. (RX 16)

Petitioner returned to PA Rahman on December 5, 2013, regarding her ongoing neck symptoms that seemed to be exacerbated with cold weather exposure. It was noted that her symptoms had begun one month earlier and occurred constantly. She requested a note to excuse her from holding an advertising sign at work outdoors because it caused neck pain. (RX 17) The records did not reflect whether a work slip was provided to Petitioner reflecting the requested restrictions.

For the work week ending on January 4, 2014, Petitioner was late three days. (RX 18)

For the week ending January 11, 2014, Petitioner was out one day due to weather and late another three days. (RX 18)

For the week ending January 18, 2014 Petitioner was late two days and called off two days (one day for a toothache and the other for a daughter's appointment). (RX 18)

For the week ending January 25, 2014 Petitioner was noted to have come in at 8:30 a.m. one morning without permission and was late getting to work on three days, left early on one day, and called off due to her daughter being sick on one day. (RX 18)

For the week ending March 9, 2014 Petitioner called off sick one day and was late on two occasions. (RX 18)

For the week ending March 14, 2014 Petitioner was late two days. (RX 18)

For the week ending March 21, 2014 Petitioner was late one day. (RX 18)

For the week ending April 4, 2014 Petitioner was late three days and took a day off for court. (RX 18)

For the week ending April 11, 2014 Petitioner was absent one day (daughter's illness) and late on two occasions. On April 10, 2014 Petitioner was called into the office and a meeting was held regarding Petitioner's late starts. (RX 18)

Respondent's records indicate a conversation was held with Petitioner on April 15, 2014 about her tardiness and reminding her that she was to start work at 9:00. (RX 18) Petitioner was late two days for the week ending April 18, 2014. (RX 18)

For the week ending April 25, 2014 Petitioner was late two days and called in absent due to a toothache another day. (RX 18)

On April 28, 2014 Petitioner stopped "marketing" and the records indicate "if not marketing, sent home." (RX 18) Petitioner was late on the 20th. (RX 18)

For the week ending May 9, 2014 (Petitioner's last day of work) Petitioner was sick one day. (RX 18)

Petitioner was terminated from her employment with Respondent on May 9, 2014, for excessive lateness on 35 occasions and 11 call-offs from January 2014 until May 2014. (R. X. 18)

Petitioner presented to PA Rachman on May 23, 2014 regarding cervicalgia, an annual exam, and atopic dermatitis. Petitioner reported her neck pain symptoms had improved on her current medication regimen. On examination Petitioner's neck was tender and she had mild pain with motion. (RX 17)

Petitioner presented to Dr. Boutwell on November 25, 2014. Per Dr. Boutwell's note, Petitioner reported that overall she did well for a period of time, but "with the added stresses and physical demands of her occupation her right upper and lower extremity symptoms, which she maintains are related to the March 31, 2011, injury had worsened." Petitioner also reported to Dr. Boutwell that, "I lose my job because I couldn't work four hours". It was noted that Petitioner was currently unemployed due to the inability of her employer to accommodate restrictions per Petitioner. (PX 4; RX 19)

On exam of the cervical spine, Dr. Boutwell noted that Petitioner's cervical spine no longer demonstrated right torticollis, range of motion was within normal limits, no muscle spasms or trigger points were identified, and previously noted minor decreased sensation in C6 dermatome had resolved. Petitioner did describe significant tenderness to palpation somewhat diffusely right greater than left. With respect to the lumbar spine, range of motion was restricted in all planes due to complaints of discomfort; however, Petitioner remained non-tender to palpation in the midline and left paraspinal areas with some significant tenderness on the right L4-S1 area. Petitioner had difficulty standing on the right foot only secondary to posterior right hip discomfort. (PX 4; RX 19)

Dr. Boutwell's assessment was recurrent subjectively escalated right upper and lower extremity radiculitis status post remote trauma in 2011. It was noted that Petitioner reported recurrence after returning to work in May, with subsequent hot/cold exposure and occupational stress beyond subjective perception of restrictions. In light of Petitioner's previously favorable response to earlier treatment (injections and therapy) Dr. Boutwell felt this was relatable to the same injury and recommended a similar course of treatment to include injections, aquatic therapy and prescription medication to include anti-inflammatories and Ultracet for breakthrough pain. Petitioner was taken off work pending follow-up. (PX 4; RX 19)

On March 12, 2015 Petitioner returned to Dr. Boutwell for "persistent, subjectively stable complaints since last visit." Her exam was essentially unchanged with Dr. Boutwell noting that while therapies had not been undertaken, Petitioner was stable with no evidence of regression. Dr. Boutwell did not keep Petitioner off of work; instead she noted Petitioner's previous permanent work restrictions. (PX 4; RX 19)

Petitioner underwent bilateral L4-5 and L5-S1 facet blocks on May 11, 2015 and a C4-5 epidural steroid injection on June 3, 2015. (PX 6)

At the request of Respondent, Petitioner underwent a Section 12 examination with Dr. Donald deGrange on June 8, 2015. Petitioner advised Dr. deGrange that her neck and low back pain were without change since the work accident. Petitioner described her accident as involving a forklift that apparently released a package which struck her across the top of her back and shoulder resulting in the onset of pain and Petitioner falling forward. Petitioner denied any new injuries, accidents or other traumas since the March 2011 accident, including motor vehicle accidents. She denied seeing a physical therapist for low back or cervical pain. (RX 15)

Petitioner's chief complaint was neck and low back pain. Petitioner's neck pain was described as diffuse suboccipital pain radiating between the shoulder blades and in her shoulders. Petitioner noticed this pain on a daily basis. Petitioner reported low back pain primarily on the right side radiating to her hip with some occasional tingling and numbness in the right leg, foot and toes. Petitioner reported her symptoms increased with all activities of daily living. Petitioner denied the ability to walk more than fifteen minutes and was taking tramadol and Naprosyn daily. Based upon his examination of Petitioner and a review of pertinent medical records, Dr. deGrange diagnosed Petitioner with cervical and lumbar strains, a herniated disc in her lumbar spine with degeneration and cervical spine degeneration with multilevel herniations. (RX 15)

Dr. deGrange opined that Petitioner's mechanism on injury on March 31, 2011 was consistent with a cervical and lumbar strain. He wrote that the accident seemed to have "aggravated a preexisting, well-established, evolving and advanced degenerative condition as revealed by [Petitioner's] MRIs. He felt the tissue injury imparted by the incident should have resolved within 3-6 months but due to her significant pre-existing degeneration they seem to have persisted well beyond. He later stated that he felt her strains had resolved with three to six months and that she had a significant motor vehicle accident 2 ½ years after the accident that appears to be the main reason for her ongoing symptoms. He felt she had reached maximum medical improvement long ago and did not need any further medical treatment or diagnostic studies. Dr. deGrange stated to a reasonable degree of medical certainty that Petitioner's current condition of ill-being was not in any way casually related to the alleged work injury, and it was neither a credible or plausible mechanism to explain symptoms four years later. Dr. deGrange noted multiple signs of symptom magnification during the examination, specifically a significant discrepancy between Petitioner's recorded and observed range of motion, gait, strength, and other components of the encounter. He opined there was no objective basis or objective findings that support permanent restrictions, and Petitioner was capable of full duty work. He felt that Petitioner had reached MMI. (RX 15)

Petitioner underwent a right L4-5 transforaminal epidural steroid injection and L5-S1 epidural steroid injection on June 17, 2015. (PX 6)

Petitioner was last seen by Dr. Boutwell on June 24, 2015. She reported that after each injection she had significant improvement, but it only lasted a few weeks secondary to not participating in formal physical therapy. Petitioner described her pain as 7/10 to 10/10, which stemmed from her right posterior neck down her right upper extremity and in her right low back down her right lower extremity. Petitioner reported that she had been off work since March 12, 2015, stating that her previous employer was not able to accommodate her current restrictions. Dr. Boutwell's examination of Petitioner was essentially normal. Dr. Boutwell recommended repeating the C4-5

injection to complete the series of injections and ordered 4 aquatic therapy visits. Dr. Boutwell did not comment on Petitioner's ability to return to work. (PX 4)

Petitioner's case proceeded to hearing on July 22, 2015. Petitioner testified that when she returned to see Dr. Taylor in May of 2013 Dr. Taylor informed her that she might not do as well with surgery due to the passage of time. As an alternative he offered noon-operative treatment modalities which Petitioner elected to try. Petitioner testified that she then proceeded with injections and aquatic therapy, both of which "worked good" and by September of 2013 Petitioner felt better than before her treatment had begun. Petitioner further testified that Dr. Boutwell then gave her permanent restrictions which Dr. Taylor agreed with. Petitioner testified she took the restrictions to Respondent and was then offered work in the REM Group office performing office work, including answering phones, filing, and scanning for four hours per day, five days a week. Petitioner testified that at the time of her release on August 6, 2013 she was only taking Naproxen. She testified that her pain was greatly improved at the time of her release from care.

Petitioner further testified that at some point in time she was asked to hold a sign outside the REM office which said "now hiring" as part of marketing to attract new applicants. Petitioner testified that she was provided with a chair to sit in and could sit or stand while outside holding the sign. She testified that her back started aching again due to holding the sign, and that it caused "wear and tear on her limbs and shoulder." Petitioner explained that it was often cold outside as it was winter time. Petitioner testified that her need for medication increased when she was asked to work outside and that one of the medications made her sleepy. On cross-examination, Petitioner could not recall when she started noticing an increase in her pain, and was unable to recall how many times she was asked to hold the sign, or how much it weighed.

Petitioner testified that during the timeframe that she was working modified duty for Respondent she had tried to see Dr. Boutwell due to increased pain, but was unable to see her. Petitioner testified that her attorney was able to get her in to Dr. Boutwell on November 25, 2014. Petitioner testified that Dr. Boutwell recommended injections and aquatic therapy but workers' compensation denied them. She then proceeded to get the injections on her own but that haven't entirely helped because she also needs the aquatic therapy. Petitioner testified that she would like the therapy authorized as she wants to return to work. Petitioner testified to recalling that she and Dr. Boutwell discussed developing a return to work plan/goals so that she could return to work. When asked if she understood what Dr. Boutwell meant in her notes about "returning to baseline function" Petitioner explained that the goal was to get her back to how she was in 2013 when she was able to work the four hour shifts but didn't have to hold the sign outside.

Petitioner acknowledged not receiving any temporary total disability benefits since November 25, 2014 except for an advancement of $3, 240.00 in April of 2015. Petitioner believes that if she receives the treatment recommended by Dr. Boutwell she should be able to return to work.

Petitioner testified that when examined by Dr. Boutwell in November of 2014 she did not tell Dr. Boutwell that she had been involved in an auto accident in September 2013.

Petitioner acknowledged being terminated in May of 2014 for absences and lateness. Petitioner testified that the reason she was late or called in was due to pain, or because she was drowsy from taking her medication.

Petitioner testified that even after she was no longer working for Respondent and holding the sign her pain did not improve.

Petitioner testified that the only time she had experienced relief in her pain since the March 31, 2011 accident was when she had the injections and therapy together. She testified that since returning to Dr. Boutwell in November 2014, she had undergone four injections but her pain had not improved because she needs the movement from physical therapy to help stop her pain. She does not feel she will improve unless the injections and therapy are performed together.

Petitioner testified that she was involved in a motor vehicle accident in September 2013. She testified that a she was hit from the side by another driver and was stunned. She testified that she went to the hospital to get checked out, but did not follow-up with her doctor or receive physical therapy. Petitioner testified that in her mind the auto accident didn't cause any additional problems and the pain did not last long. She testified that the pain was not great enough for her to go back to Dr. Boutwell or Dr. Taylor. She testified that she continued working after the accident.

Respondent called Stephanie Escalet to testify. She testified that she had been employed with Respondent for five years and had worked with Petitioner in the office on a daily basis. She testified that she was previously the staffing coordinator and handled recruiting and payroll, and was now the branch manager. Ms. Escalet testified that when Petitioner began working in the office for the first few months her job duties included filing, scanning, answering phones and some light cleaning. She testified that Petitioner never reported any complaints of pain while performing her job duties, nor did she report that she could complete any of her assigned tasks due to pain. Ms. Escalet testified that the sign Petitioner was required to hold was approximately the size of a desk calendar and weighed less than five pounds, and was made of foam. She testified that Petitioner was not asked to lift the sign over her head, was provided with headphones and a chair with armrests to sit in, and was allowed to come into the office as needed for bathrooms breaks, to cool off, and even to make hot chocolate.

The Arbitrator Concludes:

Issue (F) – Causation

Petitioner's current condition of ill-being is not causally related to the March 31, 2011 work injury. The medical evidence and Petitioner's own testimony do not support that Petitioner's current complaints are the result of the original working injury. The Arbitrator also finds Petitioner's motivation and credibility suspect.

Petitioner was released from Dr. Boutwell's care at MMI on August 6, 2013. She testified that her pain was significantly improved at that time and she resumed modified duty as provided by Respondent. Petitioner did not return to see Dr. Boutwell with complaints of ongoing pain until

November 25, 2014, over 16 months after being released from her care. Although Petitioner testified that she tried to get in to see Dr. Boutwell, no objective evidence was presented by Petitioner that any attempts were made to seek authorization for a follow-up visit due. It was not until six months after Petitioner was terminated from her employment with Respondent that she presented to Dr. Boutwell for evaluation.

It does not appear that Petitioner was having any difficulties with the modified office work duties for Respondent. Indeed, when Petitioner returned to see Dr. Boutwell in November of 2014 Petitioner referred to overall doing well for a period of time but "with the added stresses and physical demands of her occupation" her right upper and lower extremity symptoms were getting worse. At arbitration Petitioner focused her problem on the marketing aspect of her job, especially that of sitting/standing outside in the cold holding a foam sign. The Arbitrator heard the testimony of the witnesses and observed Petitioner describing the sign. She finds it difficult to believe that the task of holding the sign was as problematic as Petitioner suggested. It is also difficult to understand how holding the sign would have caused lower extremity complaints. There may have been an "added stress" at work for Petitioner but it was not directly related to any physical stress stemming from holding a sign; rather, it appears that it was related to the job duty itself as Petitioner did not want to be in that position. Petitioner's complaints when she resumed care with Dr. Boutwell were primarily subjective in nature. In this instance, the Arbitrator does not believe that Petitioner's inability to work after May 25, 2014 had anything to do with her physical injury. She had been released to return to work with permanent restrictions and those restrictions were being accommodated. Petitioner was physically capable of performing the job duties for Respondent – both outside and inside. She just didn't want to do the outside activity because it was humiliating to her.

Respondent's representative testified that at no point did Petitioner indicate that she was unable to perform her job duties because of pain, and by Petitioner's own testimony she did not request that Respondent provide authorization for a return visit to see Dr. Boutwell after she returned to work modified duty in July 2013.

According to Dr. Boutwell's records, Petitioner advised that the added stresses and physical demands of her job caused and increase in her symptoms, and that she lost her job because she could not work 4 hours. Dr. Boutwell also indicated that per Petitioner she could not work because her employer was not accommodating her restrictions. This information, which was provided to Dr. Boutwell and relied upon, was inconsistent with the evidence presented at trial. No evidence was presented that Respondent was not accommodating the restrictions previously issued by Dr. Boutwell.

Further, Dr. Boutwell was also not aware that Petitioner had been involved in a motor vehicle accident in September 2013. Although Dr. Boutwell references that Petitioner's complaints in November 2014 were similar to the complaints reported during treatment in 2011, it is clear that Dr. Boutwell did not have a complete and accurate picture of the development of Petitioner's symptoms (or lack thereof), nor was she aware of the auto accident in September 2013. While her office notes suggest that Petitioner's current condition of ill-being and need for additional treatment are related to the work accident, Dr. Boutwell did not provided a formal opinion to that effect and, more importantly, she did not have accurate and complete knowledge regarding

Petitioner's ability to work for Respondent and her motor vehicle accident in September of 2013. While Petitioner down-played the extent of that accident the Arbitrator did not find that testimony credible as it was contradicted by her own admissions to PA Rachman and the Tocuhette Regional Hospital Physical Therapy Department in October of 2013. At that time Petitioner reported neck and back pain stemming from the motor vehicle accident. She reported that "everything" was difficult for her to do as a result of that accident and she denied that it was work-related. Most importantly, Petitioner specifically stated that it all began on September 8, 2013 (the date of the car accident).

In addition to the above, Petitioner's testimony reflected other inconsistencies thereby diminishing her credibility. Petitioner denied any prior treatment or issues with her neck and back at both the 3/28/12 19(b) hearing and at the current arbitration hearing; however, the record from the prior 19(b) hearing documents otherwise. Also, Petitioner denied any follow-up care or physical therapy after the September 2013 motor vehicle accident; however, the medical records from PA Rahman and Touchette Regional Medical records document neck and back pain affecting all of Petitioner's activity as a result of the motor vehicle accident. Petitioner testified that she did not have lasting pain from the auto accident and was able to continue working, but she also alleged that she was unable to work fours hours due to the physical demands of holding a foam sign. These statements in and of themselves are inconsistent. Payroll timecards from January 2014 through May 2014 document Petitioner's call-offs and tardiness. Despite Petitioner's testimony, there was no documentation of call-offs for back and/or neck pain and doctor's visits for same. The Arbitrator also found it interesting that most of Petitioner's testimony at this hearing was proffered through the use of leading questions rather than having Petitioner testify in a more narrative fashion.

The medical records throughout Petitioner's treatment continuously document reported high levels of pain (8/10 to 10/10), but failed to document any objective findings supporting such reported high levels of pain. At the time of arbitration Petitioner continue to report high levels of pain despite recently undergoing four injections to the cervical and lumbar spine. Petitioner is of the belief that the only way she will experience relief is through injections and physical (aquatic) therapy performed in conjunction with one another.

Both Section 12 examiners in this case documented subjective complaints that were not supported by objective findings. Even Dr. Boutwell's examinations of Petitioner from 2014 and 2015 do not document any objective findings to support Petitioner's alleged ongoing cervical and lumbar complaints over four years after the work injury. Petitioner testified that it was the physical demands of lifting the foam sign that caused an increase in her symptoms; however, she testified that even after she was terminated from Respondent her complaints continued to persist six months later. If it was the sign that was so problematic one would reasonably infer that Petitioner's symptoms should have improved thereafter.

Petitioner bears the burden of proving all elements of her case, including that of causal connection. Petitioner failed to meet her burden of proof as no well-informed expert opinion was provided by Dr. Boutwell or any other treating physician. Furthermore, causation cannot be established through a chain of events as Petitioner clearly had an intervening accident of her own admission.

Issue (K) – TTD

As Petitioner current condition of ill-being is not causally related to Petitioner's accident, Petitioner's request for TTD benefits beginning November 25, 2014 through the date of trial is hereby denied. The Arbitrator further notes the absence of any off work slips after the November 25, 2014 visit. While Petitioner testified that she has looked for work since her termination in May of 2014 she submitted no objective evidence to verify any type of job search Respondent shall have a credit in the amount of $3,240.00 for TTD previously paid.

Issue (J) – Medical Expenses

In light of the Arbitrator's findings as to Issue (F), Petitioner's request for payment of medical expenses is hereby denied.

Issue (0) – Prospective Medical Care

In light of the Arbitrator's findings as to Issue (F), Petitioner's request for prospective medical care is hereby 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

Tyron Watson,

Petitioner,

vs.

NO: 14 WC 32696

16IWCC0438

Intertape Polymer Group,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical, 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 November 24, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $52,000.00. 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:
o060916
DLG/mw
045

JUN 29 2016

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

WATSON, TYRON
Employee/Petitioner

Case# **14WC032696**

16IWCC0438

INTERTAPE POLYMER GROUP
Employer/Respondent

On 11/24/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

0180 EVANS & DIXON LLC
ROBERT HENDERSHOT
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

16IWCC0438

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)

Tyron Watson
Employee/Petitioner

v.

Intertape Polymer Group
Employer/Respondent

Case # 14 WC 032696

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 29, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **3/17/14**, 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 $**34,840.00**; the average weekly wage was $**654.84**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**5987.10** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**5987.10**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

ARBITRATOR FINDS that Petitioner did meet the burden of proof with respect to the issue of medical causation. Petitioner has not reached maximum medical improvement and is entitled to the medical care recommended by Dr. Jeffrey Jones, including but not limited to the lumbar spine surgery. The Arbitrator also awards TTD benefits of $436.12 for 17 weeks. Arbitrator also finds any unpaid medical expenses occurring due to the March 17, 2014 injury is the responsibility of the Respondent.

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

11/23/15
Date

ICArbDec19(b)

NOV 24 2015

futureTYRON WATSON v. INTERTAPE POLYMER GROUP

IWCC# 14 WC 32696

STATEMENT OF FACTS

Petitioner testified that he worked for Intertape Polymer starting in June 2013. While working for Respondent, Petitioner testified that he works with large spools of tape and deals with manipulating the shafts that are placed in the core of large tape rolls. On March 17, 2014, Petitioner had a work injury where he had to grab and maneuver a shaft weighing over and hundred pounds because it was stuck in the core of the tape roll. While he was holding the shaft it became unstuck and fell towards the Petitioner. When the shaft became free, the weight of the shaft caused Petitioner to jerk forward and he experienced immediate back pain. Petitioner reported such incident and filled out an accident report with his employer. Petitioner testified that he tried to work with the discomfort, but eventually sought medical treatment.

On March 21, 2014, Petitioner saw Dr. Mark Smith at Logan Primary Care. Petitioner gave a history of his work accident and complained of his low back pain and radicular pain into his legs. Dr. Smith gave Petitioner light duty restrictions.

April 16, 2014, Petitioner saw Dr Smith with Complaints of low back pain and that the pain was also in his stomach and pelvis. Dr. Smith recommended physical therapy.

May 14, 2014, Petitioner saw Dr. Smith with increased law back pain and radiculapothy.

May 31, 2014, Petitioner underwent an MRI at Herrin Hospital.

June 2, 2014, Petitioner saw Dr. Smith for a review of the MRI and referred Petitioner out to Dr. Gerson Criste for an evaluation.

July 2, 2014, Petitioner went to see Dr. Criste. Petitioner gave the doctor a history and complained of burning low back pain and radiculapothy down both of his legs. Dr. Criste placed Petitioner on light duty and sent him to work hardening.

July 15, 2014, Petitioner saw Dr. Criste and complained that work hardening was painful and that he had continued low back pain. Dr. Criste gave Petitioner an epidural steroid injection.

July 24, 2014, Petitioner received a second epidural steroid injection from Dr. Criste.

August 4, 2014, Petitioner saw Dr. Smith and continued him in work hardening and took him off work.

August 25, 2014, Petitioner was sent by Respondent for an evaluation by independent medical specialist, Dr. Frank Petkovich. Dr. Petkovich examined Petitioner and gave the opinion that Petitioner suffered a sprain in his lumbar caused by his work accident of March 17, 2014. Dr. Petkovich recommended physical therapy and a third injection. He gave restrictions of ten pound lifting and limited bending, stooping, squatting and kneeling.

Petitioner was seeing Dr. Brian Woodard, a chiropractor, for manipulation occasionally for his back discomfort.

November 5, 2014, Dr. Criste gave Petitioner his third lumbar steroid injection.

December 16, 2014, Petitioner went to see Dr. Smith with continued complaints. Dr. Smith referred Petitioner to a neurosurgeon for further evaluation. Dr. Smith continued Petitioner on his light duty.

April 10, 2015, Petitioner was seen at the Orthopedic Institute of Southern Illinois by Dr. Jeffrey Jones.

May 7, 2015, Petitioner saw Dr. Jeffrey Jones who opined that Petitioner would benefit from a lumbar interbody fusion at L5-S1. Dr. Jones felt that this was a reasonable option because of Petitioner's failed conservative treatment and his continued pain problems. Dr. Jones gave work restrictions of 5-10 pound lift limit, no repetitive bending, stooping or squatting and no prolonged sitting.

June 1, 2015, Petitioner was terminated from his job.

July 24, 2015, the IME doctor, Dr. Petkovich completed a follow up examination. Dr. Petkovich noted that Petitioner's complaints were consistent with earlier complaints including radicular complaints into his left leg. Dr. Petkovich felt that Petitioner had suffered a sprain of his lumbar as a result of his work injury but he felt that had resolved. Dr. Petkovich felt that Petitioner had reached maximum medical improvement in regards to any problems related to the work injury of March 17, 2014.

ISSUES

F. Is Petitioner's current condition of ill-being related to the injury?

Petitioner testified that he suffered a work accident on March 17, 2014, while working as a machine operator for Intertape Polymer. Petitioner testified that he was manipulating a150 to 160 pound metal shaft out of a core of jumbo tape roll when it slipped and he went down with it while holding it. At that time, Petitioner had pain and felt he had injured his lower back.

Petitioner testified that prior to this work incident he had never had any issues with his back.

Petitioner testified that he went through a course of treatment that included physical therapy, medication, work hardening and a series of three steroid injections that were of no benefit.

Dr. Petkovich, the independent medical exam doctor, opined that Petitioner suffered a sprain of his lumbar at the time of the accident but that it had resolved and the current recommendations for surgery were not related to the March 17, 2014 incident.

Dr. Petkovich did state that the March 17, 2014, incident may have exacerbated Petitioner's pre-existing degenerative condition but it should have resolved within six weeks.

Petitioner's condition did not resolve.

Dr. Jones in his deposition opined that after seeing Petitioner and looking at his MRI study, that Petitioner had significant disc degeneration at L5-S1. Petitioner had given a history that he had no prior back symptoms prior to his work injury and that he had back pain ever since the accident. Dr. Jones felt that after going through a number of months of conservative treatment and no benefit that Petitioner needed a transformminal lumbar interbody fusion at L5-S1. Dr. Jones opined that Petitioner's current condition was causally connected to his work accident and the need for his surgical procedure was reasonable and necessary.

CONCLUSION:

Arbitrator finds that Petitioner's current condition of ill being is causally connected to his work injury of March 17, 2014.

This decision is reached on the fact that Petitioner by history and testimony was non symptomatic prior to his work injury of March 17, 2014. His condition after the accident never resolved after going through multiple conservative treatments and surgery is his best option for relief as opined by Dr. Jones.

Arbitrator finds that Dr. Jones' opinion is more persuasive than that of Dr. Petkovich in how he explains Petitioner's current condition and how Petitioner's condition is connected to the work accident claimed.

J. Were medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

CONCLUSION:

Arbitrator finds that the Respondent has not paid all appropriate charges for Petitioner's medical services and those charges are the responsibility of the Respondent.

K. Is Petitioner entitled to any prospective medical care?

CONCLUSION:

Arbitrator finds that based on the opinion of Dr. Jones, Petitioner is entitled to future medical care as recommended by Dr. Jones, which will be the Respondent's responsibility.

L. What temporary benefits are in dispute?

Temporary total disability benefits between June 1, 2015 through that date of trial, September 29, 2015. This time is representing 17 weeks of lost time.

CONCLUSION:

Arbitrator finds that Respondent is responsible for the payment of 17 weeks of TTD for time lost between June 1, 2015 and September 29, 2015.

N. Is Respondent due any credit?

CONCLUSION:

Arbitrator finds that Respondent is due a credit of $5, 987.10 for TTD paid for time off work prior to June 1, 2015.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William A. Billings,
Petitioner,
vs.

NO: 14 WC 05463

16IWCC0439

State of Illinois/IDOT,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing 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:
o060916
DLG/mw
045

JUN 29 2016

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BILLINGS, WILLIAM A
Employee/Petitioner

Case# **14WC005463**

16IWCC0439

SOI/IDOT
Employer/Respondent

On 10/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

5060 EVANS/ BLASI LLC
PETER BLASI
1512 JOHNSON RD
GRANITE CITY, IL 62040

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1430 BUREAU OF RISK MANAGEMENT
WORKERS' COMP MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

OCT 8 - 2015

RONALD A. GARCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0439

STATE OF ILLINOIS)
)SS.
COUNTY OF **Madison**)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

William A. Billings
Employee/Petitioner

v.

State of Illinois/ IDOT
Employer/Respondent

Case # **14** WC **005463**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **2/27/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Did Petitioner exceed his permissible choices of doctors?**

16IWCC0439

FINDINGS

On **10/14/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**25,678.20**; the average weekly wage was $**1,711.88**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **3** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**65,612.52** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**65,612.52**.

11/14/2015

Respondent is entitled to a credit under Section 8(j) of the Act for any medical bills previously paid or any amounts paid by the group carrier.

ORDER

Respondent shall pay reasonable and necessary medical services of $56,256.44, as provided in Sections 8(a) and 8.2 of the Act and shall reimburse Petitioner $1,530.64 for reasonable and necessary medical expenses which he paid out of pocket.

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 $1,141.25/week for 128 4/7 weeks, commencing 11/14/11 through 11/18/11 (5/7 weeks), 11/28/11 through 3/13/12 (15 2/7 weeks), and 11/26/12 through 1/22/15 (112 4/7 weeks), as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $65,612.52 for temporary total disability benefits that have been paid.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of $**695.78**/week for a further period of **86** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **40% loss of the left leg.**

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

9/24/15
Date

ICArbDec p. 2

OCT 8 2015

FINDINGS OF FACT

Petitioner William A. Billings was a 50 year old operating engineer who was employed by the State of Illinois Department of Transportation (IDOT). The Petitioner began working for IDOT in June of 2011 and was responsible for operating heavy equipment. (T-16). On October 14, 2011, the Petitioner twisted and rolled his left ankle while descending from a height of approximately 2 feet backwards off a track hoe. (T-17). The roadway he was working on was brought down 2-3 feet below the surface, was uneven and had broken pieces of concrete and rock on the surface. (T-18). When his left ankle rolled inward, he immediately felt pain and fell to the ground. (T. 18). Petitioner testified that he could feel his foot starting to swell in his boot. The Petitioner testified that he advised his supervisor but stayed to work that day because he believed the job would shut down without an operator and everyone would have to go home if he left. (T-18).

After work Petitioner sought medical treatment from St. Joseph's Hospital in Breese, Illinois. (T-19). Petitioner was seen in the Emergency Room with complaints of left ankle pain of a 9 on a 1/10 pain scale. (P. Ex. 2). The history of accident was consistent with Petitioner's testimony at trial. X-rays were taken and the radiologist reported soft tissue swelling but reported no acute fracture. Petitioner was released on crutches with a prescription for Ibuprofen and Hydrocodone and advised to follow up with his primary care physician.

The Petitioner testified that his whole foot turned black but that he kept working because he thought it was just a sprained ankle and he expected it would get better with time. (T-20). When it did not improve, Petitioner followed up with his primary care physician Dr. Rodney Greeling. (T.20).

Petitioner saw Dr. Greeling on November 14, 2011. (P. Ex 3). Dr. Greeling placed the Petitioner off work beginning on 11/14/11 through 11/21/11. (P. Ex. 3). Dr. Greeling ordered an MRI of the left ankle and also referred him for an orthopedic evaluation with Dr. Craig Beyer. (T. 21) (P. Ex 3). Dr. Greeling's record of November 14, 2011 specifically notes "MRI of ankle & ortho" under the heading "Assessment/ Plan." Petitioner testified that he believes Dr. Greeling's office made the appointment with Dr. Beyer for him following the MRI results. (T. 22). Petitioner testified that he did not recall ever calling Dr. Beyer's office to set up the appointment and that Dr. Greeling's office "sets up pretty much all of my appointments, especially if it's involving Anderson Hospital which is Dr. Beyer." (T. 63). Petitioner testified that he first treated with Dr. Beyer in 2007 and that Dr. Greeling had referred him at that time as well. (T. 66). The Petitioner testified that Dr. Greeling's referrals were oral unless he specifically requested one to be written. (T. 67).

An MRI of the left ankle was performed at Maryville Imaging on November 25, 2011. Edema was noted throughout the ankle as well as an intra-articular fracture of the lateral talar dome. Tears were suspected of the anterior talofibular ligament, posterior talofibular ligament, calcaneofibular ligament, anterior and posterior tibiotalar ligaments, the deltoid ligament, and the distal posterior tibial tendon. (P. Ex 3). The radiologist additionally noted a partial tear of the peroneus brevis tendon at the lateral ankle and fluid was noted within the peroneus tendon sheaths which he felt may be developing synovitis.

Petitioner saw Dr. Craig Beyer on November 28, 2011. Dr. Beyer reviewed the MRI and performed a physical examination. (P. Ex 4). Petitioner had a limited range of motion and had diffuse synovitis around the ankle with fluid. There was extensive edema in the lateral half of the talus with irregularity of the osteochondral surface suggesting probable chondral injury in that area. Dr. Beyer noted that the Petitioner was only 6 weeks

out from a "severe ankle sprain" and recommended a program of ice, activity modification, medication, therapy and bracing. Dr. Beyer felt that if significant pain persisted then arthroscopy may be necessary for an apparent chondral/osteochondral injury. Dr. Beyer ordered physical therapy and placed the Petitioner on restricted/light duty. Petitioner testified that the Respondent had no restricted/light duty available. (T. 47).

Petitioner underwent physical therapy at Community Memorial Hospital in Staunton. (P. Ex 8). When he returned to see Dr. Beyer on January 11, 2012 there was some modest improvement, but he still complained of swelling by the end of the day. (P. Ex 4). Dr. Beyer indicated that he was running out of "simple options. " Dr. Beyer recommended continued conservative treatment and added the recommendation of an intraarticular injection to calm inflammation. Dr. Beyer noted that he would see the Petitioner back in six weeks and unless there was substantial improvement, surgical intervention consisting of arthroscopy and a possible Brostrom reconstruction would be considered. Dr. Beyer kept the Petitioner on restricted/light duty. Petitioner saw Dr. Beyer on February 6, 2012 and March 3, 2012. At the March 3. 2012 visit it was noted that Petitioner continued to have pain, but that some of the pain is migrating to different areas. Dr. Beyer indicated that the "2 main possibilities are occult instability or chondral injury." Dr. Beyer noted that if pain persists surgery is an option and it was offered. (P. Ex 4). Dr. Byer released the Petitioner to return to work full duty on March 13, 2012. Petitioner testified that he and Dr. Beyer discussed allowing him to return to work on a trial basis before proceeding with the recommended surgery. (T. 23). Petitioner testified that at that point he was still having issues. He would take pain medication and re-position his foot in an effort to alleviate symptoms. (T. 24).

Petitioner returned to Dr. Beyer on June 13, 2012. He was noted to have improvement and to have "maximized" non-surgical treatment. (P. Ex 4). Petitioner was experiencing pain over the peroneal tendons and swelling at the end of the day. Petitioner was again counseled on the proposed surgery.

Petitioner had remained in communication with Respondent's adjuster. Petitioner credibly testified that he and the adjuster discussed obtaining a second opinion before proceeding with surgery and that Respondent referred him to Dr. Idusuyi. Respondent concedes that Dr. Idusuyi was an authorized "second opinion." (J. EX. 1) The Arbitrator further notes that Dr. Idusuyi did not provide any actual treatment, but merely provided a consultation. Dr. Idusuyi saw the Petitioner on September 22, 2012. (P. EX 5). Dr. Idusuyi 's diagnosis was "Flexor halluces longus tenosynovitis left ankle" and "Anterolateral soft tissue impingement left ankle." Dr. Idusuyi recommended a repeat MRI.MRI of the left ankle was performed on October 26, 2012 at Springfield MRI &Imaging Center. (P. EX 5). The radiologist notes non-specific joint fluid and soft tissue edema, abnormal appearance of the peroneus brevis consistent with either tendinitis or partial tear and abnormal appearance of the talar dome laterally consistent with a site of ostenonecrosis.

The Petitioner saw Dr. Beyer on November 6, 2012 where it is noted that the Petitioner continues to have persistent pain that is somewhat global. (P. Ex 4). Dr. Beyer notes that the Petitioner has stiffness and soreness that get worse at the end of the day. Dr. Beyer comments that the new MRI shows "large fluid accumulation around the FHL tendon." He notes that the "primary question is what is causing the constant irritation." Dr. Beyer notes that the new MRI is "interesting" as he appears to have an "avascular segment involving the lateral talar dome which is likely traumatic." Dr. Beyer opines that the Petitioner had edema in the area right after the original injury and that there is a reasonable chance there is articular damage or even delamination of articular cartilage above the lesion causing mechanical irritation. Dr. Beyer notes that

conservative measures have been exhausted and further indicates that he discussed with Petitioner the likelihood that he may require extensive surgery including osteoarticular reconstruction approach. Dr. Beyer recommended that the Petitioner see a foot and ankle subspecialist. Dr. Beyer also indicated that the Petitioner may want to see a doctor at a University setting such a Dr. Jeff Johnson of Washington University. Dr. Beyer released the Petitioner.

Dr. Idusuyi examined the Petitioner again on November 17, 2012. (P. EX 5). Dr. Idusuyi reviewed the MRI with Petitioner and noted the MRI findings of mild osteonecrosis and peroneal tendonitis/tear. Dr. Idusuyi recommended proceeding with "extensive surgery for the osteochondral necrosis" as he opined it was best to concentrate where the patient is having the most symptoms. Dr. Idusuyi recommended a debridement of the left ankle soft tissue impingement and synovitis with tenosynovectomy of the flexor halluces longus tendon and possible exploration of the peroneal tendons. Dr. Idusuyi noted that the Petitioner was returning to Dr. Beyer and may seek another opinion.

The Petitioner testified that he made an appointment to see Dr. Johnson, but no appointments were available until March 2013 and he wanted to get back to work by spring. (T-26). The Petitioner testified that he researched and found Dr. John Sigle of the Foot and Ankle Center of Illinois. (T. 27). The Petitioner testified that he notified the Respondent of his choice to treat with Dr. John Sigle and was told it was approved. (T. 28).

Dr. John Sigle saw the Petitioner on November 26, 2012. (P. EX 6). Dr. Sigle noted the Petitioner had pain along the peroneal tendons and on direct palpitation of the posterior ankle joint in the area of the posterior talus. Dr. Sigle reviewed the MRI and noted the finding of a lateral talar dome lesion, a possible peroneus brevis tendon tear, significant swelling around the posterior portion of the talus near the flexor hallucis longus tendon and os trigonum. Dr. Sigel recommended diagnostic injections and indicated that ankle arthoscopy would be the next step if symptoms persisted. Dr. Sigle placed the Petitioner off work.

The Petitioner returned to see Dr. Sigle on January 3, 2013 with continuing complaint of left ankle pain without improvement. (P. EX 6). Dr. Sigle notes that the Petitioner indicated that the injections helped for a few days. Dr. Sigle notes that the Petitioner was prepared to pursue surgical intervention. Dr. Sigle performed another diagnostic injection to consider possible lateral alleoli osteotomy and debridement of the talar dome lesion. The Petitioner was advised to follow up with Dr. Sigle in six weeks to see if the injection helped him. Dr. Sigle notes that he discussed possible surgical intervention as an option but that he "would need to get preapproval from his workmen's comp." Dr. Sigle was recommending an ankle arthroscopy and likely open lateral ankle stabilization procedure. In addition Dr. Sigle was recommending a gatroc recession, excision of the os trigonum/stieda process, a fibular osteotomy to address the talar dome lesion and a curettage and debridement of the osteochonral lesion. Dr. Sigle recommend the Petitioner to return in 6 weeks and it is noted that his office would seek preapproval to assume additional care and to perform the recommended surgeries.

Dr. Sigle saw the Petitioner next on February 14, 2013. (P. EX 6). Dr. Sigle notes that workers' compensation approved only two of the recommended surgical procedures. Dr. Sigle did not feel that performing only two of the surgeries would adequately treat Petitioner's pathology and this information was explained to the Petitioner. Dr. Sigle noted that he felt it was in the best interest of the patient to fix all the pathology at once. Dr. Sigle noted that the two surgeries approved by workers' compensation were scheduled

for March 1, 2013. Dr. Sigle noted that he would continue to try to get approval to proceed on all the recommended procedures because Dr. Sigle believed just proceeding with the approved surgeries would not give the Petitioner a successful outcome.

The Petitioner testified that he was told by Respondent's day labor office coordinator Stuart Hunt that his treatment with Dr. Sigle and surgical procedures were approved. (T. 68). Respondent had utilization reviews performed by MCMC dated 2/1/13 and 2/19/13 approving Dr. Sigle's treatment as "medically necessary and appropriate." (P. EX 7, see Secondary Records Scan pp. 26-27 and pp. 30-32).

The Petitioner testified that he did not proceed with the surgery scheduled for March 1, 2013, despite being approved by Respondent, because he still had an appointment with Dr. Jeffrey Johnson of Washington University Physicians and since it was already spring, he thought he might as well get his opinion. (T. 29).

The Petitioner saw Dr. Jeffrey Johnson, Washington University Physicians on March 11, 2013. (P. EX 7). Dr. Johnson took a history of the work injury and noted Petitioner's prior treatment and some of the treatment recommendations made by the other physicians. Dr. Johnson reviewed the MRI and noted the small osteochondral lesion of the lateral talar dome and inflammation with fluid in the posterior recess of the left subtalar joint. Dr. Johnson's diagnosis was status post inversion work-related ankle injury of October 2011 with persistent posterior and lateral ankle pain, sinus tarsi pain and tenderness, posterior impingement, posterior synovial impingement and a lateral osteochondral lesion. Dr. Johnson recommend proceeding with a posterior ankle arthroscopy to clean up the sinus tarsi and remove and posterior impingement. Dr. Johnson also, recommended a repeat of the injection into the subtalar posterior joint space. Dr. Johnson noted that since the Petitioner had been unable to work for so long it would probably be better just to proceed with the surgery. Dr. Johnson notes that the plan was discussed with the Petitioner and he agreed to proceed. Dr. Johnson noted that surgery would be scheduled once his office obtained approval from workers' comp. Dr. Johnson notes that the Petitioner could only perform light duty work.

The Petitioner testified that he had a choice to proceed with the approved surgeries of Dr. Sigle or Dr. Johnson and discussed the matter with Respondent. (T. 68). The Petitioner testified that ultimately he decided to go with the less invasive arthroscopic procedure recommended by Dr. Johnson. (T. 30). Dr. Johnson told the Petitioner that the surgery recommended by Dr. Sigle was very aggressive and that he could do everything arthroscopically which would cut down on the recovery time. (T. 30).

Dr. Johnson performed the arthroscopic procedure on March 26, 2013 addressing the talar dome osteochondral defect and debriding the posterior and anterior ankle joint. (P. EX 7). Dr. Johnson ordered physical therapy and kept the Petitioner off-work. The Petitioner went to Apex Physical Therapy in Maryville, Illinois. Petitioner was later released to light duty on May 6, 2013. Petitioner was examined by Dr. Johnson's fellow, Dr. Kraus for a follow up on June 3, 2013. (P. EX 7). Petitioner complained of burning sensations in his forefoot and that he could not stand for extended periods of time. Petitioner was still in a boot. Dr. Kraus notes that the Petitioner was slower to progress than anticipated. Petitioner was advised to try to wean himself off the boot. Additional physical therapy was recommended and light duty restrictions were kept in place.

Dr. Johnson saw the Petitioner for a follow-up on July 16, 2013. (P. EX 7). The Petitioner is noted as having continued pain complaints and swelling. The Petitioner is noted as saying that he feels somewhat worse

following the surgery and that his toes are numb on the plantar aspect of the forefoot. The Petitioner reports burning in many of the same spots. Dr. Johnson recommends a more aggressive program of physical therapy. Dr. Johnson keeps in place the light duty restrictions and tells the Petitioner to return in 3 months. Petitioner again underwent physical therapy at Community Memorial Hospital in Staunton. (P. Ex 8).

Dr. Johnson's records show that the Petitioner called in on August 5, 2013 complaining of foot numbness and a feeling that his foot is going to sleep. (P. EX 7). The Petitioner reported pain on the top of the foot, the lateral border and pain in the Achilles. The Petitioner reported having difficulty with physical therapy and that he feels something is going on higher in the leg. Dr. Johnson refused to see Petitioner earlier than the schedule appointment in October.

The Petitioner is seen by Dr. Johnson on August 28, 2013. (P. EX 7). The Petitioner reported to Dr. Johnson that he continues to have burning pain on the posterolateral aspects of the ankle the same as before surgery. The Petitioner also reported that over the past two months he has developed sharp pains that make it difficult for him to drive a car. Dr. Johnson discontinued a physical therapy technique recommending continuation of the more gentle modalities. Dr. Johnson continued the light duty restrictions and advised Petitioner to follow up in October when he expects the Petitioner to have reached a "healing plateau."

Petitioner returns to see Dr. Sigle on September 26, 2013. (P. EX 6). Petitioner reported to Dr. Sigle that he had arthroscopic surgery in March and now has numbness, tingling, burning and pain in his left foot. The Petitioner reported having burning and numbness on the bottom of his foot with every step. Dr. Sigle's physical exam found pain at the Achilles and a highly positive Mulder click consistent with a Morton Neuroma. Dr. Sigle found decreased ankle joint range of motion causing an overload to distal forefoot likely driving this neuroma. Dr. Sigle diagnosed the Petitioner with a Morton's neuroma, 3rd interspace left, pain, equinis, and arthritis of the ankle joint. Dr. Sigle recommended an over the counter arch support and injected the neuroma. Dr. Sigle instructed the Petitioner to follow up with his surgeon concerning the ankle and to follow up with him as needed.

The Petitioner follows-up with the Dr. Johnson for the last time on October 21, 2013. (P. EX 7). Petitioner gave a history of continued complaints of stabbing pain in the forefoot, burning pain along the lateral aspect of the foot and a decrease in sensitivity of the forefoot and toes. Petitioner also had a decrease in his ability to walk and complains of a pulling sensation in the posterior aspect of the ankle with a burning quality when on ramps or inclines. Objective testing shows slight limitations in ankle joint dorsiflexion and range of motion. Dr. Johnson noted that little had changed since his initial presentation as to complaints. He did not feel additional treatment was indicated and found Petitioner at maximum medical improvement. Dr. Johnson stated that he does "not have a good feel for what his permanent work restrictions would be" and he recommends a functional capacity evaluation to be performed. Dr. Johnson indicates that he hopes the Petitioner can get back to some kind of gainful employment given his current limitations. Dr. Johnson releases the Petitioner from his care.

The Petitioner testified that following his release from Dr. Johnson he continued to experience problems including a click or snapping in the back of his foot on the outside. (T. 33). The Petitioner testified that he felt something was still not right so he followed up with Dr. Sigle. (T. 34). The Petitioner testified that the

Respondent stopped paying the Petitioner TTD benefits following Dr. Johnson's release and have paid none through the present. (T. 36).

Dr. Sigle saw the Petitioner on November 3, 2013 with complaints of pain in the surgical areas of his left foot and a feeling of instability. (P. EX 6). The Petitioner complained of intense pain due to the Neuroma whenever he walked. The Petitioner reported that he couldn't even mow the grass due to the pain. Dr. Sigle recommended 7 injections over the next 14 weeks to treat the neuroma. The Petitioner was to return on an as needed basis. Dr. Sigle also offered a surgical removal of the Neuroma.

Dr. Greeling ordered another MRI of the left ankle from Metro Imaging on November 21, 2013. The MRI showed degenerative changes of the Talar Dome but was read by the radiologist as otherwise normal. Petitioner was referred by Dr. Greeling to see Dr. Armen S. Kelikian of Northwestern Orthopedic Institute in Chicago. (T. 34 and 58). Dr. Kelikian saw Petitioner on November 22, 2013. (P. EX 9). Dr. Kelekian diagnosed the Petitioner with an Osteochondral Lesion, Equinus deformity of the foot, Morton's Neuroma and ankle impingement syndrome. Dr. Kelikian notes that he reviewed records and scans from previous treatment and felt that Petitioner may benefit from a gatroc recession and possible peroneal tendon repair. Dr. Kelikian ordered an ultrasound to be performed. The report from the Ultra-Sound dated November 22, 2013 indicated that there was a "large longitudinal tear of the peroneus Brevis tendon" and a "Large Morton's Neuroma at the left second web space."

The Petitioner returned to Dr. Greeling on December 11, 2013. (P. EX 3). Dr. Greeling notes that the Petitioner had a complex medical history concerning his left ankle injury and is having continuing difficulties following his surgery at Barnes. Dr. Greeling records show that he was placed at restricted/light duty status for work, and a written referral to Dr. Kelikian was provided by Dr. Greeling.

The Petitioner next saw Dr. Kelikian on December 16, 2013 where he received an injection. (P. EX 9).

The Petitioner was examined at the request of the Respondent by Orthopedic Surgeon Dr. James B. Stiehl on December 18, 2013. (P. EX 12, dep ex. #2). Petitioner was noted to be tender over the puncture sites from the surgery and having severe palpatory discomfort over the peroneal tendons and the posterior tibial tendon. Pain over the sinus tarsi was also noted by Dr. Stiehl. Range of motion was noted as decreased as was sensation. Petitioner was noted as having a slight antalgic gait on ambulation. Dr. Stiehl opined that the Petitioner suffered a minor ankle sprain and that his current complaints were inconsistent with a typical recovery from a minor sprain. Dr. Stiehl opined that he found it "unlikely" that the peroneal tendon tear shown on the MRIs were "actual active pathologies." Dr. Stiehl opines that it is "unexplained" why the Petitioner's tendonitis has increased over time. Dr. Stiehl felt that the injury of October 2011 had completely resolved. Dr. Stiehl opines that the treatment to date was satisfactory and no future treatment will be successful or warranted at this time. Dr. Stiehl opined that he believes the Petitioner magnifies his complaints and the Petitioner can return to work full duty without restrictions. Dr. Stiehl opined that the Petitioner was as maximum medical improvement and provided an AMA rating of 2% of the lower extremity translating to 1% person as a whole disability.

Petitioner was seen at Community Memorial Hospital Physical Therapy Department and evaluated by Michael Coalson the director of Physical therapy on April 11, 2014. Mr. Coalson found the Petitioner to have dorsiflexion of 5 degrees on the left verses 20 degrees on the right. Upon weight bearing testing the Petitioner

was found to have 11cm restriction on the right while having a 1cm restriction on the left. According to Mr. Coalson any measurement less than 9-10cm would be considered restricted. (P. EX 6).

Dr. Greeling referred the Petitioner back to Dr. John Sigle on 4/14/14. (P. EX 3). Petitioner is seen by Dr. Sigle on April 15, 2014 complaining of terrible pain in the left foot. (P. EX 6). Dr. Sigle notes that he saw Dr. Kelikian and he had recommended a gastric secession, excision of neuroma, repair of the peroneal tendon and a possible DeNovo osteochondral grafting to the talus. Dr. Sigle notes that the Petitioner would like him to perform the operations. Upon physical exam, the Petitioner notes pain along the peroneus tendon, the anterolateral ankle joint and a positive Mulder click at the 3rd interspace consistent with a neuroma. Dr. Sigle instructs the Petitioner to return in two weeks to go over the MRI and come up with a surgical plan.

Petitioner is seen by Dr. Sigle on April 29, 2014. (P. EX 6). Dr. Sigle reviews the MRI noting an anterior talar fibular ligament tear, a large talar dome lesion and a peroneus brevis split-thickness tear. Dr. Sigle begins the first of a series of 7 injections to address the neuromas. Dr. Sigle recommends proceeding with Brostrom lateral ankle stabilization, peroneal tendon tear repair and a gastoc resection. Dr. Sigle notes that the procedure is outpatient to be performed at St. Johns Hospital in Springfield and the Petitioner will be non-weightbearing afterwards. Petitioner returned to Dr. Sigle to receive injections for the Morton Neuroma on 5/3/14. (P. EX 3). Dr. Sigle modified Petitioner's work restrictions to include not lifting more than 20 pounds and not operating heavy machinery. Petitioner followed up with Dr. Sigle on 6/2/14, 6/16/14, 6/26/14 and 7/8/14 to receive injections.

Dr. Sigle performs surgery on the Petitioner on 7/10/14 at St. John's Hospital in Springfield Illinois. (P. EX 10). Dr. Sigle performed a Brostrom Lateral ankle stabilization, an open repair of the Peroneus Brevis tendon and a Gastroc recession. Petitioner was seen in follow up on 7/11/14, 8/12/14, 8/18/14, 9/15/14. (P. EX 6). The Petitioner is noted to have improvement and to have advanced from a cast to a walking boot. Dr. Sigle also notes that he has the Petitioner doing physical therapy at Community Memorial Hosptial.

Dr. Sigle was deposed on October 28, 2014. Dr. Sigle testified that he is a board certified podiatrist practicing in Springfield Illinois for the past 10 years. (P. Ex 11). Dr. Sigle testified that when he first examined the Petitioner he found the peroneal tendons were likely torn based upon his physical examination. Dr. Sigle testified that he additionally recommended repairing the talar dome lesion which he describes as a fracture inside the ankle. Dr. Sigle testified that he sought approval for four procedures from workmans' comp but only two were approved. Dr. Sigle testified that he spoke with the case manager and discussed how it was important that all the pathology be addressed to properly treat the Petitioner's problems. Neither the peroneal tear nor the gastroc recession were authorized. The plan was to proceed with the authorized procedures until Dr. Sigle got a call that the Petitioner was proceeding with another doctor. Doctor Sigle testified that Dr. Johnson scoped the ankle from the front and back but did not perform the stabilization procedure he was previously authorized to perform. Dr. Sigle testified that a Neuroma is a nerve impingement that can be caused by the favoring one foot over the other or walking abnormally. Dr. Sigle testified that following Dr. Johnsons release the Petitioner was not at MMI because he did not have full treatment of everything. Dr. Sigle testified that following Dr. Johnson's release the Petitioner could not perform physical labor because he was having trouble walking. (P. Ex 11, p. 19). Dr. Sigle testified that Dr. Greeling referred the Petitioner to him in April 2015. (P. Ex 11, p. 24). Dr. Sigle testified that he took photographs of the peroneus tendon tear during surgery and those

tears could be found on the first MRIs. Dr. Sigle testified that based upon a reasonable degree of medical certainty that the treatment he provided was reasonable and medically necessary. Dr. Sigle testified that the surgery he performed in July of 2014 was the same he recommended two years prior. Dr. Sigle testified that the Petitioner's injury and the treatment provided were related to the injury. Dr. Sigle testified that the procedure performed by Dr. Johnson was also related to the work accident. Dr. Sigle testified that he found the Petitioner to be credible and the complexity of this injury made it difficult for the Petitioner to pinpoint pain.

The Petitioner returned to see Dr. Sigle on November 18, 2014 complaining about difficulty with lifting and working on his foot. (P. EX 6). Dr. Sigle reports that the Petitioner's ankle is still very tight and has a lot of swelling. The Petitioner is noted to have completed physical therapy. Dr. Sigle reports that the Petitioner agrees that he is improving and the majority of the pain now is on the ball of his foot. Dr. Sigle finds that the Petitioner is not a MMI and could benefit from the use of a compression sock, over the counter arch support and additional rehab. The Petitioner was advised to follow up in 2 months. Dr. Sigle suggested to the Petitioner that an option he could pursue would be to surgically remove the neuroma, fix the plantar plate and fuse the 2nd and 1st metatarsal. Dr. Sigle kept the Petitioner on the same restrictions.

The Petitioner testified that the surgery performed by Dr. Sigle helped the peroneal tendon immensely. (T-39). Prior to the surgery the Petitioner was having trouble sleeping, driving down the road, and even sitting in a chair due to the constant irritation and pain. Petitioner testified that it felt like something was crawling up his foot.

The Petitioner saw Dr. Sigle for the last time on January 22, 2015. (P. EX 6). The Petitioner reported to Dr. Sigle a 50% improvement as far as motion, but that he was still having stiffness in his ankle which he believed was causing the pain in the ball of this foot. The Petitioner reported that the peroneal tendon pain and instability was better and that he no longer experiences the pain and clicking. Dr. Sigle noted that the Petitioner still has issues with the talar dome lesion, ankle arthritis and lack of motion in the ball of the foot and that he has offered Petitioner further treatment. However, Dr. Sigle released the Petitioner to return on an as needed basis, finding him to be at maximum medical improvement.

Dr. Stiehl was deposed on February 9, 2015. (P. EX 12). Dr. Stiehl testified that he is a board certified orthopedic surgeon and he was retained by the Respondent to perform a Section 12 independent medical exam. Dr. Stiehl testified that since authoring his report, he had reviewed medical records and surgical photographs from Dr. Sigle. Dr. Stiehl testified that the Petitioner did in fact have a peroneal tendon tear and that he can't rule out that it was caused or aggravated from the work injury. (P. EX 12 p.9). Dr. Stiehl testified that the work injury of October 2011 could have caused the Petitioner's ankle to become symptomatic and the surgeries performed by Dr. Johnson and Dr. Sigle were related to injuries from the accident. (P. EX 12 p.10-11). Dr. Stiehl testified that he sees no reason why the Petitioner could not return to work at this time and he would expect Petitioner to be able to return to work six months after the peroneal tendon surgery. (P. EX 12 p.22). Dr. Stiehl agreed that prior to the peroneal tendon repair there may be "some reason for him to have restrictions." (P. EX 12 p.22-23). Dr. Stiehl does not disagree that the surgeries were reasonable and medically necessary. (P. EX 12 p.24). Dr. Stiehl testified that he does not know what is involved in the Petitioner's job. (P. EX 12 p.27

Petitioner testified that he does not have any follow up appointments scheduled and does not plan to proceed with further treatment discussed with Dr. Sigle. (T.40). Petitioner was released without restriction. (T.40). The Petitioner testified that he continues to experience nerve problems in the front of his foot consisting of sharp shooting pains, numbness, tingling depending on activities. Petitioner testified that the gastroc resection procedure effects the back of his leg and not just the foot (T.40). The Petitioner testified that his ankle is still "very stiff" and that he doesn't have the range of motion he needs. (T.40). The Petitioner testified that he avoids bending over, putting pressure on the front of the foot and avoids activities like basketball or carrying things that puts pressure on the foot. (T.41). The Petitioner testified that he avoids problems with walking or standing by lifting his foot early or putting most of the pressure on the right foot. (T.41).

The Petitioner testified and identified that the bills and receipts contained in Petitioner's exhibit 1A were paid by him out of pocket. (T. 46). The Petitioner testified that some medical bills were paid by the Respondent, some paid by his wife's health insurance plan and others remained outstanding. (T. 46). The Petitioner testified that Petitioner's Exhibit 1C represented bills not paid by the Respondent and to his knowledge no bills after October 2013 had been paid by the Respondent. (T. 46).

Petitioner's Exhibit 1(a) shows Petitioner's out of pocket medical expenses to be $1,530.64. Petitioner Exhibit 1(b) shows total medical bills to be $56,256.44. Petitioner's Exhibit 1(c) shows total bills not paid by the Respondent to total $40,413.48. Respondent claims a credit for payments of medical bills of $26,486.21 (RX 1), credit for TTD paid $65,612.52 and any group payments made if any.

CONCLUSIONS OF LAW

F. Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator finds that the Petitioner leg, ankle and foot condition are causally related to the injury. The Arbitrator finds the opinions of the Petitioner's treating physicians, particularly Dr. Beyer, Dr. Sigel, Dr. Johnson and Dr. Kelikian, that the Petitioner sustained more than An ankle sprain that lead to several ankle/foot conditions persuasive. The Arbitrator notes that even Dr. Steihl testified that the Petitioner did not have any history of prior complaints and that the accident caused at the very least an aggravation necessitating two surgical interventions. Dr. Sigle testified that because the Petitioner went untreated and was improperly treated for so long he developed additional issues including neuromas and other abnormalities due to an altered gait and the favoring of the injured leg.

J. Were the medical services that were provided to Petitioner reasonable and necessary? (Has Respondent paid all appropriate charges for all reasonable and necessary medical services?)

K. Did Petitioner exceed his choices of providers?

The Arbitrator finds that the Respondent is responsible for the medical treatment and charges associated with all the medical treatment from October 14, 2011 through January 22, 2015. The Arbitrator finds the opinions of Petitioner's treating physician, Dr. Sigle credible. Likewise, Respondent's own section 12 examiner, Dr. Stiehl conceded that the treatment the Petitioner received including the two surgeries performed were both reasonable and medically necessary. The Respondent has offered no evidence to contradict the reasonableness or the necessity of the medical treatment or the charges for the services set forth in Petitioner's

exhibit 1. The Respondent shall pay medical expenses of $56,256.44 as set forth in Petitioner's exhibit 1(b) pursuant to the fee schedule. Respondent shall also reimburse Petitioner's out of pocket medical expenses of $1,530.64 as set forth in Petitioner's exhibit 1(a).

The Arbitrator finds that the Petitioner did not exceed his choice of physicians under Section 8(a)(3) of the Act. Following the emergency room Petitioner followed up with Dr. Greeling. Dr. Greeling is Petitioner's primary care physician. His note indicates "MRI of ankle & ortho" under the heading "Assessment/ Plan." The Arbitrator finds this evidence consistent with Petitioner's credible testimony that Dr. Greeling gave him an oral referral to consult with Dr. Beyer. Dr. Beyer is, therefore within the first chain of referral.

Petitioner continued to treat with Dr. Beyer. After attempting a return to work in March of 2012 Petitioner Saw Dr. Beyer in June 2012 he was said to have maximized non-surgical options and surgery was discussed. During the entirety of his treatment Petitioner had remained in communication with Respondent. Petitioner credibly testified that he and the "case manager" discussed obtaining a second opinion before proceeding with surgery and that Respondent arranged for him to be evaluated by Dr. Idusuyi. Respondent concedes that Dr. Idusuyi was an authorized second opinion. (J. EX. 1) The Arbitrator further notes that Dr. Idusuyi did not provide any actual treatment, but merely provided a consultation. Following the consultation Petitioner continued treatment with Dr. Beyer. Finally on November 6, 2012 Dr. Beyer suggested Petitioner see a foot and ankle specialist and gave him the name of Dr. Jeff Johnson. The Petitioner testified that he made an appointment to see Dr. Johnson, but could not get an appointment until March 2013. The Arbitrator concludes Dr. Johnson is within Petitioner's first chain of referrals.

Petitioner testified that he wanted to get back to work by spring so he researched and found Dr. John Sigle of the Foot and Ankle Center of Illinois. (T. 27). Petitioner notified the Respondent of his choice to treat with Dr. John Sigle He testified that he was told it was approved. (T. 28). Respondent also obtained a utilization review which approved two of the four procedures Dr. Sigle was recommending at that time. The testimony of both Dr. Sigle and the Petitioner indicate that the Respondent had approved treatment back in February 2013 and a surgery was scheduled for March 1. The procedures were delayed because the doctor believed it was in Petitioner's best interest to address all of the pathology at once rather than simply perform the two procedures Respondent had authorized. The Arbitrator finds that Dr. Sigle was Petitioner's second choice of physician and in addition was an treating physician authorized by Respondent in February 2013.

The Arbitrator also finds that Dr. Kelikian was not outside the choice of physicians. The Arbitrator finds credible the testimony of the Petitioner which indicated it was the practice of Dr. Greeling to make oral referrals unless and until a request for a written referral is made. The Arbitrator notes that the by the time of the second visit with Dr. Kelikian Dr. Greeling had a written referral slip.

K. What temporary benefits are in dispute?

The Arbitrator notes that the Petitioner's injury was chronic and complex in nature and took a long time to diagnose and treat. The Arbitrator finds the opinions of Dr. Sigle and Dr. Greeling that Petitioner could not return to work without restrictions until January 22, 2015 persuasive. The Arbitrator notes that the Respondent's own section 12 examiner Dr. Stiehl agreed some restrictions prior to the peroneal tendon tear would be reasonable. The Arbitrator finds credible the testimony of the Petitioner that no light duty was made available

by Respondent and the record reflects that the Petitioner attempted to return to work or inquire about restricted duty positions. Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is entitled to temporary total disability from November 14, 2011 through November 18, 2011; November 28, 2011 through March 13, 2012 and November 26, 2012 through January 22. 2015 for a total of 128 4/7 weeks.

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 a January 17, 2014 impairment rating of 2% of the left lower extremity as determined by Dr. Stiehl, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (P. EX 12). 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 was at MMI and in need of no further treatment at that time. At the time of his deposition on February 9, 2015, however Dr. Stiehl testified that since authoring his report, he had reviewed medical records and surgical photographs from Dr. Sigle which showed that the Petitioner did in fact have a peroneal tendon tear. (P. EX 12 p.9). Dr. Stiehl testified that the surgery performed by Dr. Johnson and the surgery performed by Dr. Sigle were related to injuries from the accident. (P. EX 12 p.10-11). Dr. Stiehl testified that he sees no reason why the Petitioner could not return to work at this time. Dr. Stiehl testified that he would expect the Petitioner to be able to return to work six months after the peroneal tendon surgery. (P. EX 12 p.22). However, Dr. Stiehl agreed that a torn peroneal tendon could "hurt" and that prior to the peroneal tendon repair there may be "some reason for him to have restrictions." (P. EX 12 p.22-23). Dr. Stiehl does not disagree that the surgeries were reasonable and medically necessary. (P. EX 12 p.24). Because Dr. Stiehl's rating was prepared before the doctor had considered all the relevant evidence, 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 operating engineer 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 Petitioner does have significant residual symptoms which involve the leg and not just the foot and ankle. Because of Petitioner's on going difficulties performing his job, the Arbitrator therefore gives *lesser* 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. Because of he will suffer the increased discomfort for a longer period than an older worker, 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 there was no evidence in the record to establish Petitioner has suffered a reduction in future earnings capacity. Therefore The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that although the Petitioner has been released full duty without restrictions, Dr. Sigle's records and testimony reflect continuing chronic pain issues and limits to the Petitioner's range of motion. The Arbitrator found Petitioner's testimony concerning his reduction in physical activities, including walking and standing, credible. The Arbitrator also notes that the record supports that this injury has affected

the Petitioner's whole lower extremity and not just his foot. Because Petitioner's on going symptoms are consistent with the medical records, 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 40% loss of use of Petitioner's left leg pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Adela Moreno,

Petitioner,

vs. NO: 10 WC 12081

Total Maintenance Management, Inc.,

Respondent.

16IWCC0440

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, medical expenses, temporary total disability benefits, permanent disability benefits, and penalties and attorney's fees, 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 notes that accident was not in dispute in this case. The Commission further notes that the medical records show that Petitioner did not suffer from headaches from a concussion or pain from bulging cervical discs and lumbar facet syndrome prior to the March 7, 2010 work accident. Petitioner's treating physicians, Dr. Perez and Dr. Engel, opined that Petitioner's condition was causally related to the undisputed work injury. Dr. Perez opined that Petitioner's condition "is directly related to the work injury she sustained on 03/07/2010." (PX5) Dr. Engel noted that Petitioner "had no neck or back pain prior to her fall on 03/07/2010. Therefore, her fall is the direct cause of her current pain complaints." (PX5,PX6) The April 7, 2010 MRI of Petitioner's cervical spine showed 2-3mm centrally located disc protrusions from C3-C4 through C5-C6. (PX5) and the lumbar spine MRI, also performed on April 7, 2010, showed disc desiccation at L3-L4 and changes of facet arthropathy at L5-S1. (PX5) The medical records indicate that Petitioner was asymptomatic prior to March 7, 2010, but has had neck and back pain since the March 7, 2010 accident. Furthermore, there is nothing in the record to indicate that Petitioner suffered any additional accident or injury after March 7, 2010. Therefore, based on the totality of the evidence, the Commission agrees with the Arbitrator that Petitioner has established that her current conditions of ill-being are causally related to the March 7, 2010 undisputed work accident.

In regards to Petitioner's medical expenses, the Commission notes that Petitioner's medical treatment was authorized by utilization review through October 14, 2010. Petitioner was also released to return to work, full duty, on October 14, 2010. Specifically, Dr. Engel noted that Petitioner was pain free and discharged her from pain management treatment. (PX5,PX6) However, Petitioner returned following an aggravation of her back condition at work on December 16, 2010. (PX5,PX6) Petitioner underwent another round of conservative treatment,

including medial branch blocks and on February 23, 2011, Dr. Engel noted that Petitioner was pain free and released her from care and back to work full duty. (PX5,PX6) After this, Petitioner suffered from back pain and dizziness when performing strenuous work; Therefore, on June 1, 2011 Dr. Perez restricted Petitioner from performing strenuous activity at work. (PX5) It was after the application of work restrictions by Dr. Perez that Petitioner's condition stabilized. Therefore, the Commission finds that Petitioner finally reached maximum medical improvement on June 1, 2011, when she was released to return to work with permanent restrictions and discharged from care for the last time. Therefore, the Commission hereby modifies medical award and awards medical expenses through June 1, 2011.

On the issue of penalties and attorney's fees, the Commission agrees with the Arbitrator's decision to not award penalties and fees based on Dr. Walsh's Section 12 examination report. The Commission finds that it was not unreasonable for Respondent to rely on the opinions of Dr. Walsh. Furthermore, while certain treatments were initially denied by utilization review, they were ultimately approved following appeals of the initial denials. Therefore, Respondent's defense of this claim was not unreasonable or vexatious.

While the Commission has decided not to impose penalties and attorney's fees in this case, it notes that medical expenses incurred by Petitioner prior to Dr. Walsh's August 26, 2010 Section 12 report was issued, as well as medical treatments approved by utilization review remain unpaid by Respondent despite the fact that Respondent stipulated to accident in this case. The Commission finds Respondent's continued decision to not pay for medical expenses not in dispute disconcerting and establishes the basis for an award of penalties and attorney's fees in the future should Respondent continue to behave in such a manner.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. Furthermore, we have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 5, 2015 is modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $271.82 per week for a period of 12-4/7 weeks, from March 8, 2010 through June 2, 2010 and from September 27, 2010 through September 28, 2010, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner all medical bills incurred in treatment as a result of the March 7, 2010 accident through June 1, 2011.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability benefits of $271.82 per week for 50 weeks, because the injuries sustained caused the 10% loss of use of the person as a whole as provided in Section 8(d)2 of the

Act.

16IWCC0440

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,000.00. 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:
MJB/ell
o-06/21/16
52

JUN 29 2016

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORENO, ADELA
Employee/Petitioner

Case# **10WC012081**

TOTAL MAINTENANCE MANAGEMENT INC
Employer/Respondent

16IWCC0440

On 1/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% 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:

1922 SALK, STEVEN B & ASSOC LTD
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0507 RUSIN & MACIOROWSKI LTD
JENNIFER JONES
10 S RIVERSIDE PLZ SUITE 1530
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

ADELA MORENO
Employee/Petitioner

v.

TOTAL MAINTENANCE MANAGEMENT, INC.
Employer/Respondent

Case # **10** WC **12081**

Consolidated cases: _____

16IWCC0440

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **November 3, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **March 7, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**14,023.54**; the average weekly wage was $**271.82**.

On the date of accident, Petitioner was **32** years of age, ***married*** 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 $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**10,119.28** for other benefits, for a total credit of $ **10,119.28**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Respondent shall be given credit for $**10,119.28** for **medical** benefits paid under Section 8(a) of the Act.

Respondent shall pay to Petitioner all medical bills certified by utilization review until October 14, 2010.

Respondent shall pay Petitioner temporary total disability benefits of $ **271.82**/week for **12&4/7** weeks, commencing **03-08-10** through **06-02-10**, and **09-27-10** through **09-28-10**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $ **271.82**/week for **50** weeks, because the injuries sustained caused the **10%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

No penalties are awarded in this matter.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

01-03-15
Date

JAN 5 - 2015

Adela Moreno v. Total Maintenance Management, Inc.

10 WC 12081

FINDINGS OF FACT 16IWCC0440

On March 7, 2010, the Petitioner, Adela Moreno, a 32 year old Hispanic female, married with 4 children under 18, was employed by the Respondent, Total Maintenance Management, Inc., as a housekeeper. She was assigned to clean the common areas of the Ford City Shopping Center. Her duties included mopping floors, cleaning tables in the food court, cleaning bathrooms, sinks and toilets and emptying trash bins.

On the day of the accident, the Petitioner was working the evening shift. At approximately 8:00 p.m., she finished mopping the food court and it was time for her lunch break. She went to get her co-worker Cecilia Zubia to go on break. The Petitioner went into the washroom where Ms. Zubia was working, washed her hands, turned and slipped and fell on the damp freshly mopped floor. She fell backwards, striking her head on the floor.

Her co-worker assisted the Petitioner up from the floor and called mall security for help. The mall security then called the Chicago Fire Department and an ambulance transported the Petitioner to Holy Cross Hospital.

At Holy Cross Hospital, the Petitioner was treated and released with a diagnosis of head contusion and lower back pain. She was prescribed Flexeril and Tylenol #3.

The next day she went to Alivio Medical Center, where her personal physician practices. She stated she lost consciousness when she struck her head and was unable to move her head from side to side. She was diagnosed with a head concussion and was instructed to return to the emergency room.

She then went to the University of Illinois Medical Center emergency room. There she gave a history of the accident, complaining that the pain in her head and back continued to increase. She was diagnosed with a contusion and muscle sprain. She was prescribed Diazepam and Ibuprofen and was told not to perform any heavy lifting for one week.

On March 9, 2010, she returned to Alivio Medical Center complaining of continued headache. A CT scan was ordered and she was taken off work until March 12, 2010.

The CT scan was scheduled for March 18, 2010 at Mercy Hospital. The Petitioner called Alivio Medical Center and spoke with her doctor on March 11, 2010. At that time she was prescribed physical therapy and the off work order was extended to March 18, 2010.

Due to payment issues, the CT scan did not occur until March 19, 2010. The CT scan report was benign and the brain was within normal limits.

Following the CT scan, the Petitioner called Alivio to obtain the results but she was unable to discuss the results with a doctor. The Petitioner then sought treatment at Marque Medicos with Dr. Fernando Perez, D.C., on March 22, 2010.

Dr. Fernandez took a history of the accident from the Petitioner and noted that the Petitioner complained of headaches, neck, mid and low back pain. Dr. Perez's exam noted tenderness to palpation throughout the paraspinal musculature with decreased range of motion. His diagnosis was cervical thoracic and lumbar sprain/strain, headaches. He prescribed physical therapy and kept the Petitioner off work. He also believed that the Petitioner's condition was causally connected to the slip and fall accident of March 7, 2010.

In a follow-up appointment on April 6, 2010, the Petitioner complained of continued intense pain and severe headaches with dizziness. At that time, Dr. Perez ordered an MRI and continued physical therapy. He kept the Petitioner off work.

The MRI taken on April 7, 2010 at Archer Open MRI revealed disc protrusions at C3-4, C4-5 and C5-6. It also showed disc dessication at L3-4 and facet arthropathy at L5-S1. On April 9, 2010, Dr. Perez thought that the MRI findings correlated clinically to the mechanism of injury and complaints. He referred the Petitioner to Dr. Engel at Medicos Pain & Surgical Specialists, continued physical therapy and ordered an EMG/NCV test. He kept the Petitioner off work.

The EMG/NCV test taken on April 26, 2010, revealed acute denervation of the S1 nerve root.

The Petitioner was examined by Dr. Engel, M.D., at Medicos Pain & Surgical Specialists on April 22, 2010. After taking a history, reviewing the MRI and conducting an exam, Dr. Engel diagnosed lumbar facet syndrome, low back pain syndrome, cervical herniated discs and cervicalgia. He prescribed continued physical therapy, pain medications and kept Ms. Moreno off work.

The Petitioner was re-examined by Ms. Stacy Pond, a physician's assistant for Dr. Engel, on May 27, 2010. Ms. Pond prescribed continued medication and physical therapy, but gave the Petitioner a light duty release to return to work with a 10 pound lifting restriction and to limit bending. The release was to be effective as of June 1, 2010 and the Petitioner actually returned to work on June 3, 2010.

During this time period, the Petitioner received physical therapy at Marque Medicos and continued to see Dr. Perez about once per month.

On June 23, 2010, the Petitioner saw Stacy Pond and stated that the cervical pain was 0/10 and lumbar pain was 2/10. Ms. Pond stopped prescription medications, but continued to prescribe physical therapy. However, by July 22, 2010, the lumbar pain increased to a 4 or 5/10. Ms. Pond prescribed the prior medication and discussed the possibility that the Petitioner might

need diagnostic branch block injections. Ms. Pond did continue the light duty work restrictions at that time and continued to prescribe physical therapy.

On September 2, 2010, the Petitioner again saw Dr. Engel. At that time, the Petitioner complained of 6/10 pain in her low back. Dr. Engel recommended the diagnostic branch block injections, prescribed medication and continued physical therapy. He also continued the 15 pound light duty lifting restriction.

On September 27, 2010, Dr. Engel administered the first left L5-S1 diagnostic medial branch block injection. Dr. Engel took the Petitioner off work for two days.

The Petitioner returned to Dr. Engel on October 14, 2010 and claimed she was pain free. Dr. Engel stopped physical therapy, stopped prescriptions and returned the Petitioner to full duty work, discharging her from pain management.

Unfortunately, the Petitioner was laid off from work on September 29, 2010 and remained off work until December 10, 2010. Despite not working, by December 16, 2010, the Petitioner's low back pain increased and Dr. Engel recommended a second confirmatory L5-S1 medial branch block injection.

Dr. Engel administered that injection on December 22, 2010. On January 16, 2011, Dr. Engel recommended a radiofrequency L5-S1 medial branch ablation because of the positive findings from the two previous branch block injections. The radiofrequency ablation was administered on January 19, 2011 and the Petitioner was taken off work by Dr. Engel through January 23, 2011. The Petitioner returned to full duty work on January 24, 2011.

On January 27, 2011, Dr. Engel noted that the Petitioner complained of 4/10 back pain with mid-back muscle spasms. He prescribed Soma and physical therapy.

On February 23, 2011, Dr. Engel again discharged the Petitioner from his care. His final diagnosis was thoracic spine pain, lumbar facet syndrome, cervical herniated discs and headaches. Dr. Engel recommended home exercises and recommended that the Petitioner take over-the-counter medications as needed.

On June 1, 2011, the Petitioner returned to see Dr. Perez, D.C. at Marque Medicos. The Petitioner at that time complained of intermittent low back pain, dizziness and headaches, especially when performing heavier work. After Dr. Perez conducted an exam, he placed a 50 pound lifting restriction on the Petitioner and told her to avoid repetitive motions.

At the Respondent's request, pursuant to Section 12 of the Act, the Petitioner was examined by Dr. Kevin Walsh on August 26, 2010. Dr. Walsh was of the opinion that the Petitioner's diagnosis was neck, mid-back and lower back pain with subjective numbness in her neck and back. He believed that none of her complaints, symptoms or diagnosis were caused by the accident of March 7, 2010, and that her treatment was not reasonable or necessary.

On April 27, 2012, Dr. Engel wrote a note to the Petitioner's chart in response to Dr. Walsh's Section 12 report. In that note, Dr. Engel opined that the Petitioner's condition was caused by the March 7, 2010 accident. He did agree that the MRI findings pertaining to the cervical sprine may or may not have been caused by her fall, but Dr. Engel thought that the fall aggravated her condition to the point where she needed treatment.

Dr. Engel also believed that the March 7, 2010 fall was the cause of the Petitioner's lumbar facet syndrome. Dr. Engel based this opinion on the fact that the pain started after an acute episode. If it was degenerative as Dr. Walsh opined, the pain would have been expected to return after the ablation to the same intensity that the Petitioner had early in the case.

The Petitioner testified that she never received any temporary total disability benefits. She testified that she continues to have severe headaches and back pain. She takes over the counter medications when she gets headaches or back pain. She has continued to work for the Respondent at the Ford City Shopping Mall.

The Petitioner also submitted medical bills that totaled $65,441.85 after applying the fee schedule.

Proofs were closed on November 3, 2014.

CONCLUSIONS OF LAW

F. Is the Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the accident of March 7, 2010.

The Arbitrator finds that as a direct result of the fall on March 7, 2010, the Petitioner suffered a concussion resulting in headaches, aggravation of cervical bulging discs and lumbar facet syndrome, all of which had to be medically treated.

The Arbitrator relies on the treating medical records and the fact that the Petitioner did not have these problems prior to the accident. Some weight is given to the opinions of Dr. Walsh.

The Arbitrator further notes that the back pain and headaches for which the Petitioner received medical treatment in 2006 at Alivio were related to complications with child birth and had completely resolved prior to the accident of March 7, 2010. The Petitioner had no subsequent accidents.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator finds that some of the medical services that were provided to the Petitioner were reasonable and necessary. The Arbitrator finds that the Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

The medical services that were provided to the Petitioner were reasonable and necessary to alleviate her condition of ill-being as a result of the March 7, 2010 accident. The treatment that the Petitioner received including the injections, allowed her to return to full duty work on October 14, 2010. No medical bills after this date are awarded.

Respondent is entitled to a credit for any medical bills paid to the date of the hearing.

Therefore, the Arbitrator, pursuant to the fee schedule, awards to the Petitioner all medical bills certified by utilization review until October 14, 2010. No medical bills after this date are awarded.

K. What temporary total disability benefits are in dispute?

The Arbitrator finds that the Petitioner was off work from March 8, 2010 through June 2, 2010, then an additional two days from September 27 through September 28, 2010.

The Petitioner was originally taken off work by her physician at Alivio Medical Center on March 9, 2010 following her visit to the emergency room at Holy Cross Hospital where she was taken by Chicago Fire Department Ambulance on the date of the accident and the University of Illinois Medical Center where she went on March 8, 2010 due to severe increasing pain. She was kept off work by the doctors at Alivio Medical Center through March 22, 2010. The medical staff at Marque Medicos and Medicos Pain & Surgical Specialists kept the Petitioner off work from March 22, 2010, when they first saw her, through June 2, 2010. The Petitioner returned to light duty work on June 3, 2010.

Following an injection and a nerve ablation, Dr. Engel kept the Petitioner off work from September 27, 2010 through September 28, 2010.

L. What is the nature and extent of the injury?

The Arbitrator finds that as a result of the March 7, 2010 accident, the Petitioner sustained injuries that caused a 10% loss to the person as a whole, as provided by Section 8(d)(2) of the Act.

As a result of the accident, the Petitioner suffered a concussion, the aggravation of three bulging discs in her cervical spine that were asymptomatic prior to the accident and lumbar facet syndrome.

She still has headaches and back pain and takes non-prescription medication for the pain.

M. Should penalties or fees be imposed upon Respondent?

No penalties are awarded in 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SERGIO GARCIA,

Petitioner,

vs. NO: 03 WC 10231

ARROW LOGISTICS,

Respondent.

16IWCC0441

DECISION AND OPINION ON REVIEW PURSUANT TO §19(h) OF THE ACT

This matter comes before the Commission pursuant to Petitioner's Section 19(h)/8(a) Petition. A hearing was held before Commissioner Michael J. Brennan on July 10, 2015. This matter was subsequently before Commission on June 21, 2016. After reviewing the record in its entirety and being advised of the facts and applicable law, the Commission hereby denies Petitioner's 19(h) Petition finding Sergio Garcia failed to establish a material increase in his condition as required in Section 19(h) of the Act. The Commission, however, grants Garcia's Section 8(a) Petition and awards medical expenses totaling $30,790.22. Respondent is entitled to a credit for all amounts paid.

By way of procedural history, Garcia filed an Application for Adjustment of Claim on February 28, 2003 alleging that on November 21, 2002 a tire fell onto his left leg causing a fracture. This matter was tried before Arbitrator Kurt Carlson on November 23, 2010.

During the arbitration hearing of November 23, 2010, Garcia alleged injury to his left leg, left foot and low back. The Arbitrator found that Garcia failed to prove that his low back condition was causally related to the accident. The Arbitrator, however, awarded 50% loss of use of the left leg as the incident resulted in a fracture of the left tibia and fibula, which necessitated an open reduction and internal fixation. As a result, Garcia sustained permanent swelling, pain,

and varicosities of the left leg. The Arbitrator also awarded 5% loss of use of the left ankle as Garcia had persistent swelling and venous stasis issues as a result of the accident.

The Arbitrator examined Garcia's left leg and noted there was some residual swelling and significant scarring. Joint Exhibit 1. pg.14. Petitioner's skin was purple all around the shin especially on the inside of the shin area. His skin was raised, discolored, purple and red. The discoloration appeared to be on the inner aspect of the leg and foot. Joint Exhibit 1. pg.18. It covered the top and all around the ankle. There appeared to be vein damage and there was varicose vein development. Joint Exhibit 1. pg.15. The discoloration and varicose veins went all the way down into his foot area. Garcia's calf was swollen and his pant leg barely fit over his calf. Joint Exhibit 1. pg.16. The Arbitrator questioned whether his description did justice to the amount of damage there was to the left leg. Joint Exhibit 1. pg.17.

Garcia subsequently filed its 19(h)/8(a) Petition on March 20, 2013. Per the Petition, Garcia argued that he had been diagnosed with stasis ulcers and venous insufficiency as a direct and proximate cause of the original accident. This new diagnoses, they argue, represented a material increase in the disability. This matter proceeded to hearing before Commissioner Michael Brennan on July 10, 2015, at which time Garcia testified through a Spanish interpreter.

Garcia continued to seek medical treatment subsequent to the November 23, 2010 Arbitration hearing. Garcia was seen by Dr. Abdel Fahmy of Martin Russo Family Health Center on August 22, 2011. Examination revealed redness and pain in the left leg. The handwritten note indicated that Garcia had an 8 year history. Garcia described white bumps like mosquito bites that formed then ruptured. PX.12.

Garcia presented to Mount Sinai Hospital ER on September 14, 2011 with a history of pain, discharge and swelling in his leg. He reported discharge for the past two days that seemed to have become worse, and there was more swelling, redness and pain in the lower left leg. Garcia reported his prior fracture and that he developed swelling and pain for the past month with "on and off" worsening of his symptoms. Examination of the left leg revealed swelling and redness in the lower 1/3 of the leg with an open wound that had serosanguineous exudates from two areas which was a 1x1 cm area. The surrounding area had redness and tenderness present. There was some darkness about 10x6 inches. There was generalized edema of the lower extremity with varicose veins. There was no DVT, but the Doppler study revealed venous insufficiency. The impression was left leg cellulitis, varicose veins, chronic dermatitis, status post fracture of the left leg, and status post fixation. PX.8.

Garcia was transported via ambulance to Alexian Brothers on November 4, 2011. Per the hospital record, Garcia bumped his left lower leg against some brackets causing his varicose vein to open and begin to bleed. The left leg was swollen and discolored. He had a history of varicose veins in the left leg with chronic swelling post surgery. He had a history of stasis ulcers and brushed his leg against a rack causing it to bleed. Examination of the left lower leg revealed chronic skin changes with dark discoloration medially at and above the ankle. There were two

stasis ulcers noted medially without evidence for infections. There were multiple varicose veins noted and a small pinprick area at a varicose vein noted that appeared to be bleeding earlier. Garcia was returned to work. PX.7.

Garcia testified he was at work when his vein burst, but he did not strike anything when it burst. T.50.

Garcia presented Dr. Jason Magnani of Mount Sinai on November 29, 2011 for an orthopedic consultation. He was previously in the ER on September 14, 2011 for venous stasis ulcers. X-ray revealed that the prior fracture was completely healed and there was no sequela from the surgery except for the venous insufficiency that developed from the trauma. Garcia had improved cellulitis for which antibiotics were prescribed, and an ulcer on the tibia that was a slow healing vascular insufficiency ulcer. Garcia described that one of his vascular veins ruptured and had bled a lot. Dr. Magnani recommended that Garcia see a vascular surgeon for his venous stasis ulcer and varicose veins. PX.8.

Garcia was seen by Dr. Daniel Katz on December 19, 2011 for his venous stasis ulcer. Examination revealed a moderate amount of fibrinous material at the base of the 3x3 cm left medial calf ulcer. Garcia had soft varicosities in the calf and periwound erythema. The wound was debrided into the subcutaneous tissue. All nonviable tissue was removed. Dr. Katz noted that Garcia would likely need a venous duplex for insufficiency and radiofrequency ablation to prevent recurrence of the ulcer. PX.8.

On September 1, 2012, Dr. Sanjay Patari of Sports Orthopaedics authored a letter to Garcia's attorney. Dr. Patari noted that he last examined Garcia on November 8, 2004. He was now asked to review additional records from 2004 through 2011. Dr. Patari noted that Garcia suffered from venous stasis ulcers and venous insufficiency that was related to the left lower leg fracture. Garcia developed a delayed union, which was an indication of a possible circulatory compromise requiring the use of a bone stimulator. Garcia also subsequently developed a small ulceration on the area of the distal wound. Dr. Patari noted that had Garcia not had any vascular injury from the fracture, there would not have been any edema present during his June 7, 2004 examination, which there was. A subsequent EMG revealed peroneal nerve damage to the left lower extremity that was due to the original injury. Dr. Patari further noted that if Garcia were to develop spontaneous venous insufficiency from unknown causes, Garcia most likely would have had vascular abnormalities in both legs. The fact that Garcia did not have any vascular abnormality in the right leg led him to opine that Garcia's development of venous stasis ulcers, chronic venous insufficiency and venous stasis disease was directly related to the tibia fracture. A Venous Doppler study was recommended. PX.1.

Garcia underwent a Section 12 examination with Dr. Rajeev Garapati of Illinois Bone and Joint on February 4, 2013. Garcia had issues with wound varicosities, swelling and venous insufficiency of the left lower extremity. Dr. Garapati noted that Garcia had venous insufficiency, friable skin and varicose veins on the left lower extremity that was directly due to

the injury of November 2002. Garcia's condition had progressed to cause his current symptoms. Garcia had significant trauma to his soft tissue and skin which put him at risk for wound problems on the left lower extremity. This was directly related to the injury. He would benefit from compression stockings and a bilateral arterial and venous dopplers. PX.13.

Garcia was seen by Dr. Daniel O'Carroll on April 29, 2013 for left leg and left ankle pain. Examination revealed well-defined dyscascular area venous malformation in the anterior compartment of the left leg, possible slight malunion of the left tibia, swelling in the left ankle, swelling in the PT and peroneal sheaths, evidence of relative stress on the left ankle, and early chondromalacia in the left ankle. There was some scarring over the suspect area in the anterior and posterior medial compartment over the fracture line and significant retinacular cyst and fascial scarring. There was also significant venous malformation and evidence of adhesion in the left ankle. There was some swelling extending into the extensor hood and PT tendon sheath. PX.5.

Garcia was seen by Dr. J. Gordon Wright of Midwest Vein Center on June 3, 2013. The complaints were bilateral varicose veins with other complications, swollen lower extremity, bulging of varicosities and pain. Garcia had purities that had been getting worse over the last two years. The area of dermatitis was obviously a venous stasis dermatitis based upon its location, its association with varicose veins, and its association with other findings. Garcia had swelling in the legs over the past two years which was resolved each morning and would get more severe throughout the day. There was swelling with pain in the ankles and numbness in the areas that were most swollen. Garcia had problem with bulging of his varicosities that was especially bad after prolonged standing or sitting and was progressively worse for some time now. When the bulging was severe, it was associated with localized pain and tenderness. His history included significant injury to the foot in 2002 and a venous stasis ulcer in 2012. The exam of the left leg revealed areas of dark discoloration of the skin overlying the anterior, medial, posterior, and lateral aspect of the calf and ankle, in a so-called gaiter distribution. The area of discoloration was obvious hemosiderin deposits due to long standing chronic venous insufficiency based upon its gross appearance and association with other physical findings. Garcia had at least CEAP clinical class C4a Skin Pigmentation or Eczema. There was severe venous edema from the knee to the ankle. There was some varicose vein measured between 3 and 6 mm of the leg. PX.1.

The Venous Duplex study of the right leg was not performed as there was no clinical indication to warrant the study. The left leg revealed incompetence of the left pi-2, pi-4, pi-3 and pi-1 vein. The deep vein system was reflux positive from the proximal to mid portion of the popliteal vein on the left side but showed no sign of a DVT. The CEAP classification was C4a skin pigmentation or Eczema and swollen left leg. PX.1.

Garcia underwent endovenous abiation of several left perforator veins on June 25, 2013 and July 3, 2013. PX.1.

Garcia was seen by Dr. Wright on July 3, 2013 for continued swelling and pain in the left leg. Dr. Wright noted Garcia had varicose veins of the left thigh and calf and when compared to earlier studies, there were fewer and smaller varicose veins. The impression was left leg edema that was not due to DVT, and residual symptomatic varicose veins of the left leg with pain and inflammation despite adequate closure of an incompetence perforator veins on the left leg. Garcia was advised to wear a compression stocking. PX.1.

Garcia underwent a reflux study on October 21, 2013 that revealed reflux in the left short saphenous vein from the knee to the ankle. PX.1.

Respondent obtained a records review from Dr. Richard Carroll on March 31, 2014. Dr. Carroll noted that Garcia developed varicosities and left lower extremity edema secondary to the accident. Given the severity of the venous disease on the left compared to the right, the accident was at least contributory to the venous disease on the left. The treatment had been reasonable and continued treatment was appropriate. The right leg varicose veins and venous insufficiency was not related. RX.2.

Garcia was seen by Dr. Harold Jaimes of Jaimes Medical Group on April 10, 2014 for varicose veins, leg pain and leg swelling status post left leg trauma. Garcia had a history of recurrent ulcerations and underwent multiple incompetent perforating veins without success. Garcia had continued left leg swelling that improved with use of a compression hose. Garcia's swelling was better as long as he used the compression hose. Garcia was given a low dose diuretic for his edema. The assessment was varicose veins of the lower extremities with inflammation. PX.10.

During the July 10, 2015 hearing, Garcia testified that he noticed a different feeling in his leg with an increase in pain since 2011. The Commissioner examined Garcia's leg and noted several lumps, which were possible varicosities that were visible on the lower calf on the inside. There was some discoloration of the ankle that was slightly above the ankle into the upper portion of the foot, and some discoloration below the ankle and into the arch of the foot that was similar to bruising. T.31. Garcia testified that he has always felt pain in the ankle and at the location of the fracture. T.33.

Garcia further testified that his pain affects his job. He currently sits and drives a forklift full-time. He has to be careful getting off the forklift as his pain is unbearable if he strikes the inner part of his leg T.35. This can happen once a month or many months can go by as he is always protecting himself. *Id.* The pain is similar to a burning sensation and is immense. T.36.

Garcia testified that the compression stocking helps with the swelling. T.36. He stated, however, that his compression stocking has not worked for months. T.52. He does not take any medication for the swelling. T.37. He has not had any new infections since he was treated at Mount Sinai. T.38. He experiences pain when the weather changes as it is part of having a fracture. *Id.* This is still the same since 2011. *Id.* Sometimes his foot will hurt when he walks. *Id.*

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He stated that the injection has helped a lot. *Id.* The only treatment available to him is continued use of the compression stocking. T.53. He has no follow-up appointments. T.54.

Pursuant to Section 19(h) of the Act:

> [A]s to accidents occurring subsequent to July 1, 1955, which are covered by any agreement or award under this Act providing for compensation in installments made as a result of such accident, such agreement or award may at any time within 30 months... after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended.

In *Gay v. Industrial Commission*, 178 Ill. App. 3d 129, 132 (1989), the Illinois Supreme Court explained that:

> [t]he purpose of a proceeding under section 19(h) is to determine if a petitioner's disability has "recurred, increased, diminished or ended" since the time of the original decision of the Industrial Commission. (Ill. Rev. Stat. 1985, ch. 48, par. 138.19(h); *Howard v. Industrial Comm'n* (1982), 89 Ill. 2d 428, 433 N.E.2d 657). To warrant a change in benefits, the change in a petitioner's disability must be material. (*United States Steel Corp. v. Industrial Comm'n* (1985), 133 Ill. App. 3d 811, 478 N.E.2d 1108.) In reviewing a section 19(h) petition, the evidence presented in the original proceeding must be considered to determine if the petitioner's position has changed materially since the time of the Industrial Commission's first decision. (*Howard*, 89 Ill. 2d 428, 433 N.E.2d 657.) Whether there has been a material change in a petitioner's disability is an issue of fact, and the Industrial Commission's determination will not be overturned unless it is contrary to the manifest weight of the evidence. *Howard*, 89 Ill. 2d 428, 433 N.E.2d 657; *United States Steel Corp.*, 133 Ill. App. 3d 811, 478 N.E.2d 1108.

The Commission finds that Garcia failed to establish a material increase as required by Section 19(h). The medical records fail to establish any increase in his condition. Per the Petition, Garcia argues that the venous insufficiency and stasis ulcers are a new diagnoses. The record, however, does not support Garcia's argument. Per Dr. Holmes' June 17, 2008 Section 12 report (*See* Joint Exhibit 1) Garcia was diagnosed with venous stasis disease and noted to have varicosities in the left leg.

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Further, the Arbitrator viewed Garcia's left leg on November 23, 2010 and noted swelling, scarring, discoloration and varicose vein issues. The viewing during the July 10, 2015 hearing also revealed discoloration and varicosities.

Following the Arbitration hearing, Garcia underwent continued treatment for pain, swelling and varicosity issues. On one occasion, he was treated for a ruptured varicose vein when he bumped against an object at work. Other than that one incident, the post-arbitration treatment was for pain, swelling and varicose vein issues, which were conditions and issues he had prior to the first hearing. Further, Garcia's current subjective complaints are similar to his subjective complaints during the first hearing.

The record establishes that Garcia had pain, swelling and discoloration, venous stasis and varicosities prior to the Arbitration hearing. Those conditions were all present after the Arbitration hearing. Accordingly, the record fails to establish a material increase in his condition; therefore, the Commission denies Garcia's Section 19(h) Petition.

The Commission, however, grants Garcia's 8(a) Petition. Respondent concedes that the expenses are reasonable. Their lone argument is that they are entitled to a credit for all amounts paid and that the expenses be awarded pursuant to the fee schedule. All the opinions indicate that the treatment has been reasonable, necessary and related to the original accident. As such, Garcia is entitled to medical expenses totaling $30,790.22, subject to the medical fee schedule. Respondent is entitled to a credit for all amounts paid.

IT IS THEREFORE ORDERED BY THE COMMISSION Petitioner's 19(h) is denied and his 8(a) Petition is granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses totaling $30,790.22, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARCIA, SERGIO
Employee/Petitioner

Case# **03WC010231**

ARROW LOGISTICS
Employer/Respondent

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On 1/5/2011, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.19% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0786 MARVIN A BRUSTIN LTD
CHARLES E WEBSTER
100 W MONROE SUITE 400
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY
THOMAS MALLERS
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS.
COUNTY OF)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SERGIO GARCIA,
Employee/Petitioner

Case # **03 WC 010231**

v.

Consolidated cases:

ARROW LOGISTICS,
Employer/Respondent

16IWCC0441

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **KURT CARLSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **NOVEMBER 23, 2010** . After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **11/21/2002**, 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 $**30,044.34**; the average weekly wage was $**585.47**.

On the date of accident, Petitioner was 30 years of age, ***married*** with 0 dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $14,660.21 for TTD, $0. for TPD, $0. for maintenance, and $0. for other benefits, for a total credit of $**14,660.21** .

Respondent is entitled no credit under Section 8(j) of the Act.

ORDER

Medical benefits – none awarded.

Permanent Partial Disability: Schedule injury
Respondent shall pay Petitioner permanent partial disability benefits of $ **351.28** per week for **107.75** weeks, because the injuries sustained caused the **50 %** loss of the **left leg**, and **5%** of the **left foot** as provided in Section 8(e) of the Act.

Penalties – none 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

01-04-11
Date

JAN - 5 2011

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sergio Garcia,

Petitioner,

v.

Arrow Logistics,

Respondent.

Court No. 03 WC 010231

16IWCC0441

DECISION OF THE ARBITRATOR

FACTS:

On November 21, 2002, Petitioner was unloading a trailer when a tire approximately six feet tall fell on his left leg. Petitioner was taken to Glen Oaks Hospital Emergency Room where he was diagnosed with a fracture of the left tibia and fibula. Petitioner underwent ORIF surgery. Petitioner followed up with Dr. Patari after surgery was completed.

Medical records of Dr. Patari indicate that the Petitioner was initially released to return to full duty work on November 3, 2003. Dr. Patari later placed the Petitioner on a 25 pound lifting restriction on December 1, 2003. Additional records of Dr. Patari indicate that on June 7, 2004, the Petitioner was again given a full duty release and was also released from care.

Petitioner did not seek further medical attention until October, 2004 when he was seen by Dr. Patari for bilateral foot complaints. He was referred to Dr. Suchy. The Petitioner completed a history form in which he indicated that his complaints began approximately two months before, or approximately August, 2004. These records also indicate that the Petitioner had begun work as a landscaper at the time that he had the

onset of these complaints. Dr. Patari indicated that the Petitioner's complaints were not due to the fracture sustained in November, 2002. He again released the Petitioner to return to full duty work on November 8, 2004.

Petitioner next sought medical treatment with Dr. Chmell on June 14, 2005. At that time, Petitioner indicated to Dr. Chmell that he was driving a forklift. Petitioner complained of pain and swelling to the left leg. X-rays were undertaken on September 1, 2005 which showed the fractures had completely healed. Petitioner subsequently underwent an EMG in 2006 which was negative for radiculopathy.

The Petitioner then contacted Dr. Orellano. Petitioner first reported complaints of back pain on August 1, 2007. An MRI was prescribed at that time. This was completed in November, 2007. Petitioner then returned to Dr. Chmell on February 11, 2008 for these complaints.

Petitioner underwent an independent medical evaluation with Dr. Player at Respondent's request. Dr. Player and Dr. Chmell testified by way of deposition regarding the Petitioner's back complaints. The testimony of Dr. Chmell indicates that he initially saw the Petitioner from June 14, 2005 through September 20, 2005. This was to address the Petitioner's complaints of pain and swelling to the left leg. The doctor also prescribed an EMG which was conducted on June 27, 2006 which was positive with regard to the tibial and peroneal nerve. Dr. Chmell opined that these findings would be permanent. He also noted that x-rays taken on September 1, 2005 showed five degrees of angulation at the fracture site which he also opined would be permanent. (T. 7-12).

Dr. Chmell did not again see the Petitioner until February 11, 2008. On this occasion, Dr. Chmell reviewed an MRI that had been taken in November, 2007 of the Petitioner's lumbar spine. Dr. Chmell indicated that this MRI revealed a disc herniation at the L5-S1 level. He opined that this herniation was caused as a result of the accident

of 2002. On August 3, 2009, Petitioner was seen for a consultation by Dr. Youderian on referral from Dr. Chmell. This was a referral for physical therapy to address the Petitioner's back complaints and to treat the Petitioner's left leg for complaints of pain, swelling and weakness. Dr. Chmell testified that the Petitioner would be able to work at a sedentary job. He also indicated that the Petitioner's findings of varicosities of the left leg would be a permanent finding and due to the accident of November 21, 2002.

However, Dr. Chmell also acknowledged that when he initially met with the Petitioner on June 14, 2005, the Petitioner had no complaints of back pain, nor did he document any limp by the Petitioner or altered gait. He further acknowledged that when he met with the Petitioner on September 20, 2005, he imposed no work restrictions. (T. 29). Likewise, the Petitioner had no complaints with regard to his low back at that time. Further, he acknowledged that the Petitioner's residual of five degree of angulation at the fracture site was within the standard of care for the type of fracture the Petitioner sustained. (T. 30). He also acknowledged that when he met with the Petitioner on June 23, 2006, the Petitioner had no complaints of back pain and that he again did not impose any work restrictions. He also acknowledged the Petitioner was directed to return as needed at that time. (T. 32). Dr. Chmell further acknowledged that the first time the Petitioner raised complaints of back pain was when the Petitioner was seen on February 11, 2008. He further acknowledged the Petitioner's history was of complaints of back pain for two years, which would predate the Petitioner's last prior visit with Dr. Chmell, when the Petitioner had reported no back complaints. Dr. Chmell finally acknowledged that his records of November 24, 2008, constituting his next visit with the Petitioner, did not include any documentation that the Petitioner was placed on any work restrictions. (T. 38-39). Likewise, when last seen on August 3, 2009, there was no documentation of any work restrictions imposed by Dr. Chmell. In fact, Dr. Chmell acknowledged that he had never actually provided the Petitioner with any restrictions with regard to his working activity. (T. 43).

Dr. Player testified that he examined the Petitioner on four occasions. Dr. Player noted that at the time of his initial evaluation in August, 2003, Petitioner had no complaints to the lumbar spine nor was he directed to undertake an evaluation of the lumbar spine. He further noted that at the time of his initial evaluation, the Petitioner reported no other complaints other than to his left leg. (T. 17).

Dr. Player undertook a second evaluation of the Petitioner on March 5, 2004. Petitioner again reported complaints to his left leg only. (T. 21). At that time, the doctor's examination showed some persistent findings of swelling with regard to the left leg and particularly the lower left leg near the ankle. (T. 24). The doctor also noted a normal non-antalgic gait with fluid flexibility while walking on heels and toes during the course of his examination. (T. 26). Dr. Player also observed the Petitioner showed no evidence of an altered gait, reported no complaints with regard to walking or standing, and exhibited no signs of any change or alteration in terms of standing or walking.

Dr. Player next examined the Petitioner on June 10, 2008. Prior to this evaluation, he reviewed the Petitioner's MRI films of November 18, 2007 which Dr. Player opined revealed findings consistent with degenerative disc disease at L2-L3 and L5-S1 with a disc bulge at the L5-S1 level. (T. 31) He also obtained a history from the Petitioner that the Petitioner did not experience any complaints of back pain until June, 2005. (T. 31). Petitioner also indicated that he had returned to his normal forklift driving job in March, 2004, was laid off due to a work slow down, and then began working in various jobs as a landscape laborer beginning in the Summer of 2005 through 2007. (T. 32). Petitioner's physical examination revealed a normal non-antalgic gait with easy ability to rise and walk on both heels and toes with no measurable lower extremity atrophy. (T. 35). He also had normal reflexes and no loss of muscle strength in the left lower extremity as well as normal sensation. (T. 36). He also exhibited a negative sitting and

supine straight leg raising test. (T. 36)

Dr. Player noted that the first recorded or documented complaint of low back pain in those records he received was made by the Petitioner to Dr. Chmell in 2008. Dr. Player diagnosed the Petitioner with a lumbar sprain with left radicular subjective complaints. Dr. Player opined that there was no causal relationship between the accident of November 21, 2002 and the Petitioner's lumbar complaints at the time that he met with the Petitioner on June 30, 2008. Dr. Player went on to explain that the Petitioner, per his own history, did not have lumbar complaints until approximately 2005, almost three years after the accident in question. Dr. Player also noted that the MRI demonstrated degenerative findings with no neural compressive pathology identified. (T. 42).

Dr. Player last examined the Petitioner on June 24, 2010. Petitioner indicated that he had worked for several companies since 2008, including work as a forklift operator, landscape laborer, and snow remover. Petitioner reported that his complaints had not changed with regard to his left leg. He noted that his leg would get tired after putting weight on it for a period of time. Petitioner noted that the pain would come and go and was located diffusely over the entire left tibia and from the left knee to the ankle. Dr. Player found these complaints would be consistent with the Petitioner's fracture to the left leg. Petitioner also reported intermittent low back complaints, sometimes significant enough to require him to take a break at work. He was also using over-the-counter medication to address his complaints. (T. 48). Physical examination also showed continued, but reduced, swelling of the left calf as compared to the right. The balance of the Petitioner's physical examination appears to have been negative. (T. 51-52). Dr. Player indicated his opinions with regard to the Petitioner's left leg and with regard to the lumbar spine, previously noted, were unchanged.

Dr. Player also noted the Petitioner does have a five degree angulation in valgus.

Dr. Player noted that valgus angulation is acceptable up to 15 degrees and Petitioner's angulation was at six degrees, which would cause no functional deficit. (T. 57). He specifically found that this angulation did not result in a change in the Petitioner's gait pattern so that there would be no causal relationship between the Petitioner's accident, the permanent finding of angulation and his back complaints. Dr. Player also opined that the three year gap between the Petitioner's accident and the onset of his complaints to his lumbar spine (according to his testimony) or five year gap between the Petitioner's accident and the recording of any complaints to his lumbar spine led to the conclusion that there was simply no temporal connection between the accident of November 21, 2002 and the Petitioner's lumbar complaints. Dr. Player also disagreed with Dr. Chmell that the Petitioner sustained abnormal loading of his lumbar spine, due to the fracture to his left leg. He acknowledged that the Petitioner would have had abnormal loading in the initial phase following his accident, yet the Petitioner had no back complaints during that time. By the time the Petitioner reached maximum medical improvement with regard to his left leg injury in March, 2004, the Petitioner had a normal gait, so that there would be no abnormal loading and, thus, no causal relationship between the Petitioner's left leg injury and his back complaints.

Finally, Dr. Player opined that the Petitioner was able to return to work without restriction both with regard to his left leg and to his lower back. Further, Dr. Player acknowledged the Petitioner would have permanent varicosities on his left leg due to chronic lymphoedema. Dr. Player opined these findings would be due to the accident that occurred on November 21, 2002.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING WHETHER THE PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE ACCIDENT OF NOVEMBER 21, 2002, THE ARBITRATOR FINDS THE FOLLOWING FACTS.

There is no doubt that the Petitioner sustained a significant fracture to his left leg as a result of the accident of November 21, 2002. This accident led to permanent swelling, lymphoedema, and varicosities of the left leg. The Arbitrator had the opportunity to observe the Petitioner's left leg and it was clearly more swollen than the right. The left leg also exhibited the varicosities referenced by the Petitioner's various treating physicians. The Arbitrator finds therefore that the Petitioner's left leg complaints, with permanent sequeale, is related to the accident of November 21, 2002.

The Arbitrator further finds, however, that the Petitioner has failed to establish a causal relationship between the accident of November 21, 2002 and his lumbar complaints. The Arbitrator notes that the Petitioner was noted to have a normal gait by the time he was released to return to work in July, 2003. The Arbitrator further notes that there was no indication, during the Petitioner's subsequent treatment in 2004 and 2005 of back complaints, nor was there any indication of any abnormal loading to the lumbar spine as a result of an altered gait due to Petitioner's factures.

Further, the Arbitrator notes that the only physician to opine a causal relationship between the Petitioner's accident and his back complaints is Dr. Chmell, who did not begin to treat the Petitioner until 2007. Moreover, Dr. Chmell, himself, did not record any lumbar complaints by the Petitioner, despite providing treatment to the Petitioner in 2005 and 2006, until the Petitioner was seen in 2008. In addition, Dr. Chmell's records fail to document an altered gait, limping or any other basis to support Dr. Chmell's opinion of abnormal loading to the lumbar spine as a result of Petitioner's

accident. The Arbitrator therefore concludes that there is no causal relationship between the Petitioner's lumbar complaints and the accident of November 21, 2002.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING WHETHER MEDICAL SERVICES PROVIDED TO THE PETITIONER WERE REASONABLE AND NECESSARY, THE ARBITRATOR FINDS THE FOLLOWING FACTS.

The Arbitrator finds that the Petitioner's treatment by Dr. Chmell beginning in 2008 and treatment at the University of Illinois Hospitals was to address the Petitioner's lumbar complaints. The Arbitrator has found this treatment is not related to the accident claimed herein and therefore finds that these bills shall not be the responsibility of the Respondent.

Furthermore, the Arbitrator finds that any medical bills incurred by Dr. Orellano constitute medical treatment rendered by a physician beyond the Petitioner's two choices of physicians. The Arbitrator therefore finds that any medical bills from this physician are not the liability of the Respondent.

WITH REGARD TO WHETHER PETITIONER SHALL BE ENTITLED TO PENALTIES OR ATTORNEY'S FEES, THE ARBITRATOR FINDS THE FOLLOWING FACTS.

Petitioner sustained an initial injury on November 21, 2002. The Petitioner was not found to be at maximum medical improvement by Dr. Patari until 2004. Respondent paid for all medical bills and treatment related to the Petitioner's left leg up until the time of the Petitioner's full duty release. Further, the Respondent paid for all TTD benefits claimed by the Petitioner during his absence from work.

The only basis for any claim for penalties and attorney's fees would be any claim for payment of medical bills or lost time subsequent to March, 2004. There is no

indication that the Petitioner lost any time from work subsequent to March, 2004. Medical bills offered by the Petitioner from the University of Illinois Hospitals and Dr. Chmell for treatment to the Petitioner's lumbar spine would not be related to the accident claimed herein and nonpayment cannot justify the basis for imposition of penalties or attorney's fees.

The Arbitrator further finds that based on the fact that the Petitioner was found to be at maximum medical improvement by Dr. Patari in 2004, it would be reasonable for Respondent to dispute liability for medical bills incurred by the Petitioner with Dr. Chmell for any additional treatment to the left leg in 2005 and 2006. It appears, however, that none of the medical bills submitted relate to this treatment. Even if this were the case, however, the Arbitrator finds that the Respondent shall not be assessed penalties or attorney's fees for nonpayment of bills given the delay by the Petitioner in obtaining treatment from Dr. Chmell and the prior full duty release and release from care of the Petitioner by his initial treating physician, Dr. Patari.

WITH REGARD TO THE NATURE AND EXTENT OF THE PETITIONER'S INJURIES, THE ARBITRATOR FINDS THE FOLLOWING FACTS

The Petitioner sustained a severe fracture to the left tibia and fibula requiring ORIF surgical repair. The Petitioner has been left with permanent swelling and varicosities of the left leg. Petitioner also reports ongoing complaints of pain to the left leg which the Arbitrator finds credible. Further Dr. Patari and Dr. Player agree that Petitioner is able to return to work without restriction with regard to his left leg and Dr. Chmell has acknowledged he has never imposed restrictions on Petitioner's return to work.

Dr. George Holmes examined the petitioner at the request of respondent on June 17, 2008 and declared that the petitioner's venous stasis issues were partially exacerbated by the accident and also measured persistent swelling in the left ankle to be

partially exacerbated by the accident as well. He recommended that the petitioner use TED stockings to help control the swelling throughout the course of the day, but stated that the petitioner could return to work without restrictions.

As a result of the above, the arbitrator specifically excluded the diagnosis of bilateral plantar fasciitis and the petitioner's lumbar herniated disc at L5-S1 from his causal connection awards. Given the above, the Arbitrator finds that the Petitioner sustained permanent partial disability to the left leg to the extent of 50% thereof and 5% of the petitioner's left foot.

The Arbitrator fails to find an odd-lot or wage differential award as the weight of the evidence indicates, as well as his own post-accident behavior, that he is able to work with no restrictions. He has suffered no loss of trade as he continued to work a fork-lift operator after his accident, regardless of Dr. Chmell's opinion.

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF DUPAGE)	☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LaSonya Gilliam,

Petitioner,

vs. NO: 11 WC 17166

Illinois Department of Juvenile Justice,

16IWCC0442

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, medical expenses 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 modifies the decision of the Arbitrator to find that Petitioner sustained the permanent partial loss of use of 10% of her right hand pursuant to §8(e)9 of the Act.

Furthermore, the Commission clarifies the decision of the Arbitrator to find that Respondent is entitled to a credit per the stipulation of the parties for the payment of Petitioner's full salary for the period from 4/12/11 through 4/12/12 in addition to a credit for TTD paid in the amount of $36,619.06 as noted on the Request for Hearing form. (Arb.Ex.#1). The Commission finds that this period represents 52-2/7 weeks, and not the 53-3/7 weeks noted in the Arbitrator's decision, and that said credit would be at the TTD rate of $758.36 per week (or $39,651.39). The Commission also specifically finds that Respondent is not entitled to a credit for the five (5) service-connected days that Petitioner used from 4/5/11 until Petitioner began receiving her full salary on 4/12/11.

16IWCC0442

Finally, the Commission corrects two (2) clerical errors in the decision of the Arbitrator. With respect to the first such error, the Arbitrator had found that the period of TTD extending from 4/5/11 through 3/22/13 and from 7/4/13 through 11/3/13 was equal to 120 weeks. This period actually equals 120-1/7 weeks, given the extra leap year day in February of 2012. With respect to the second clerical error, the Arbitrator used a PPD rate of $682.52. However, the maximum PPD rate for the date in question is $669.64. The Commission hereby corrects both of these errors.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $758.36 per week for a period of 120-1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 102.725 weeks, as provided in §8(d)2 and §8(e)9 of the Act, respectively, for the reason that the injuries sustained caused the permanent partial loss of use of 16.445% of a person-as-a-whole and 10% of the right hand.

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: JUN 3 0 2016
o:5/9/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GILLIAM, LaSONYA
Employee/Petitioner

Case# **11WC017166**

ILL DEPT OF JUVENILLE JUSTICE
Employer/Respondent

16IWCC0442

On 3/3/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0320 LANNON LANNON & BARR LTD
MICHAEL S ROLENC
200 N LASALLE ST SUITE 2820
CHICAGO, IL 60601

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLECTHER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT SYSTEMS
WORKERS' COMP CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

MAR 3 - 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0442

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

LaSonya Gilliam
Employee/Petitioner

v.

Illinois Department of Juvenile Justice
Employer/Respondent

Case # 11 WC 17166

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 **Wheaton**, on **9/12/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ___

FINDINGS

On **April 4, 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 **$59,152.08**; the average weekly wage was **$1,137.54**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **2** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$36,619.06** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$36,619.06**. Respondent shall also be given a credit for the amount of Petitioner's full salary or extended benefits for the period of **April 12, 2011** through **April 12, 2012**, which is **53-3/7** weeks.

Respondent is entitled to a credit of **$1,911.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$758.36**/week for **120** weeks, commencing **4/5/2011** through **3/22/2013** and from **7/4/2013** through **11/3/2013**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical service of **$57,274.82**, pursuant to Section 8(a) and subject to Section 8.2 of the Act. Respondent shall also pay Petitioner **$30.00** as a reimbursement of out-of-pocket payments.

Respondent shall be given a credit of **$8,449.00** for medical benefits that have been paid to Trinity Hospital and, by agreement of the parties, Respondent shall be given a credit for any payments made to any of the other providers listed in Petitioner's bills exhibit.

Respondent shall be given credit of **$1,911.00** for medical benefits that have been paid through the group insurance carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided under Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$682.52**/week for **82.225** weeks, because the injuries sustained caused the **16.445%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$682.52**/week for **30.75** weeks, because the injuries sustained caused the **15%** loss of the right hand, as provided in Section 8(e)9 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.

Brian T. Cronin

March 2, 2015

FINDINGS OF FACT

Petitioner testified she is employed by the Illinois Department of Juvenile Justice as a Juvenile Justice Specialist. She has been employer there for 13 years. Her job duties include ensuring the safety and security of juveniles who are under her supervision. The juveniles are teenage inmates who have been charged with various offenses and sentenced to jail.

On April 4, 2011, Petitioner was having breakfast in the cafeteria. There was a group of inmates in the cafeteria involved in a verbal altercation and she went over to assist a co-employee to de-escalate the situation. In so doing, one of the inmates started swinging at the other. Petitioner testified that she was struck in the front and the back. Petitioner further testified that she caught "90% of the blows." She testified that she injured her head, neck and right shoulder as a result of this incident.

On that same day, Petitioner was seen by her family physician, Dr. Omerovic, at Advocate Health Center - Beverly. She informed the doctor of the incident and told her that it happened at work. Dr. Omerovic examined her and diagnosed her with acute post-traumatic headache, concussion, neck strain, and near syncope. Dr. Omerovic recommended Petitioner obtain a CT of her brain, a psychiatric exam and authorized her off work.

On April 13, 2011, Petitioner returned to Dr. Omerovic with complaints of swelling in her right shoulder along with headaches, blurry vision, and dizziness. Petitioner also complained of pain with lifting her arm.

On April 19, 2011, Petitioner underwent a CT scan of her brain at High Tech Medical Park. The CT scan revealed some attenuation in the sinuses compatible with sinusitis, which could be the source of her headaches.

On April 27, 2011, Petitioner was seen by Glinda Fitzgerald, a licensed clinical professional counselor. Petitioner told her she was physically attacked at work. Ms. Fitzgerald diagnosed her with post-traumatic stress disorder. Petitioner had one follow-up appointment with Ms. Fitzgerald on May 4, 2011.

On June 20, 2011, Petitioner began a course of physical therapy at Physiotherapy Associates.

On July 1, 2011, Petitioner returned to Dr. Omerovic with continued complaints of right shoulder pain. Dr. Omerovic ordered an MRI and referred Petitioner for an orthopedic consultation.

On July 12, 2011, Petitioner underwent the MRI of her right shoulder at High Tech Medical Park. The MRI revealed a full thickness tear of the anterior rotator cuff with tendinopathy.

On August 1, 2011, Petitioner saw Dr. John Sonnenberg at Midland Orthopedic Associates, L.L.C. She was complaining of pain in her right shoulder. Dr. Sonnenberg reviewed the MRI and opined that Petitioner was in need of shoulder surgery since conservative treatment would not help her.

On August 23, 2011, Petitioner underwent a shoulder arthroscopy, repair of the rotator cuff and subacromial decompression with debridement of the glenoid labrum at Mercy Hospital.

On August 31, 2011, Petitioner returned for a post-op visit with Dr. Sonnenberg, who recommended physical therapy. Petitioner began the course of physical therapy on September 26, 2011 at Physiotherapy Associates. Petitioner was discharged from physical therapy on November 9, 2011, after attending 30 sessions.

On November 23, 2011, Petitioner returned to Dr. Sonnenberg with issues with stiffness in her right shoulder. He noted persistent impingement in the shoulder. He recommended she continue with physical therapy.

Petitioner returned to Dr. Sonnenberg on January 9, 2012 who noted that, Petitioner's shoulder was becoming stiff due to her lack of physical therapy. He gave her a steroid injection.

Petitioner then began physical therapy at ATI on January 17, 2012 and was discharged form such physical therapy on May 2, 2012, after attending 34 sessions.

Petitioner returned to Dr. Sonnenberg on February 6, 2012 at which time she received another injection.

On March 12, 2012, Dr. Sonnenberg noted he was not happy with Petitioner's overall progress and was concerned about persistent inflammation of the rotator cuff. He recommended another steroid injection.

On April 16, 2012, Petitioner saw Dr. Sonnenberg who recommended she undergo another MRI.

On May 9, 2012, Petitioner underwent a right shoulder MRI at High Tech Medical Park. The MRI revealed the previous surgical changes to be overall intact; however, the os acromiale was unstable. It also revealed biceps tendinopathy with splitting through the intra-articular portion of the tendon.

Petitioner returned to Dr. Sonnenberg on May 14, 2012, who opined that her biceps tendon had deteriorated possibly due to persistent impingement. He recommended a CT scan and continued to authorize her off work.

On May 17, 2012, Petitioner underwent the CT scan at High Tech Medical Park. The CT scan revealed an unfused os acromiale, post-surgical changes and degenerative changes in her right shoulder.

On May 23, 2012, Dr. Sonnenberg reviewed the CT scan and recommended a repeat arthroscopy of her right shoulder.

On June 26, 2012, Petitioner underwent arthroscopic surgery involving an excision of the os acromiale, subacromial decompression, and biceps tenodesis at Mercy Hospital.

Petitioner returned to Dr. Sonnenberg on July 2, 2012 at which time he recommended a physical therapy program. Petitioner began such program on July 9, 2012 at ATI. Petitioner was discharged from physical therapy on November 5, 2012, after attending 45 sessions.

On August 15, 2012, Petitioner underwent a Section 12 examination with Dr. Gregory Nicholson, who confirmed that the rotator cuff tear occurred after a work-related altercation. Dr. Nicholson opined that Petitioner's condition was causally related to the accident and was not at MMI due to the recent surgery. He confirmed that Petitioner still needed rehabilitation and could not do full-duty work.

On October 3, 2012, Petitioner returned to Dr. Sonnenberg. Dr. Sonnenberg wrote, *inter alia*, the following: "I am concerned that she complains that the fingers tingle in the morning. I have prescribed the night brace for this with the assumption that this is probably carpal tunnel syndrome. She does have a mildly positive Tinel's sign at the wrist but a negative Phalen's test at the right wrist."

On November 5, 2012, Petitioner returned to Dr. Sonnenberg who noted: "She is developing signs of right carpal tunnel syndrome of the right hand. This may be post-operative carpal tunnel due to the therapy with which we have been very aggressive. I would, therefore, like to obtain EMG and nerve conduction study of the right hand to confirm the diagnostics." He also noted "clicking" in Petitioner's right shoulder and ordered a CT scan of the shoulder.

On November 13, 2012, Petitioner underwent the right shoulder CT scan at High Tech Medical Park. No abnormalities in the AC joint were noted, although there were persistent osteoarthritic changes in the glenohumeral joint.

On November 26, 2012, Petitioner returned to Dr. Sonnenberg with continuing complaints of impingement-type problems of her right shoulder.

Dr. Sonnenberg also noted: "She also has problems with carpal tunnel syndrome of the right hand. This carpal tunnel syndrome has come to the forefront since her injury and may be related to the extensive therapy that she has had. She currently has a positive Tinel's sign and a positive Phalen's sign of the right carpal tunnel. I cannot give any other cause for occurrence of the right carpal tunnel because she does not have any significant risk factors such as diabetes or thyroid problems, only mild obesity."

Dr. Sonnenberg recommended that she continue with physical therapy and remain off work.

On December 3, 2012, Petitioner began another round of physical therapy at ATI. She completed this round on January 11, 2013, after undergoing 15 sessions.

On December 18, 2012, Petitioner underwent an EMG at Christ Hospital. The findings were consistent with right carpal tunnel syndrome.

On December 31, 2012, Petitioner returned to Dr. Sonnenberg who reviewed the EMG of her right upper extremity with Petitioner. Dr. Sonnenberg opined that such EMG showed a definite carpal tunnel syndrome of the right hand. The doctor gave Petitioner an injection to the right carpal tunnel.

On February 4, 2013, Petitioner followed up with Dr. Sonnenberg still complaining of symptoms in her right hand. He recommended she continue with her physical therapy.

On March 4, 2013, with Petitioner still complaining of right wrist pain, he again injected her right carpal tunnel. He noted pain and decreased sensation in the median nerve distribution.

On March 13, 2013, Petitioner underwent a second Section 12 examination with Dr. Nicholson. Dr. Nicholson opined that Petitioner sustained a post traumatic work related rotator cuff tear with a repair of the deltoid long head of the biceps. He recommended work conditioning followed by an FCE and sedentary work.

On March 20, 2013, Petitioner returned to Dr. Sonnenberg with continued complaints of pain in the right wrist and right shoulder. Dr. Sonnenberg administered a steroid injection into Petitioner's right wrist on May 1, 2013. Since the injection did not help Petitioner, Dr. Sonnenberg recommended surgery.

On May 1, 2013, Petitioner returned to Dr. Sonnenberg due to increased pain of her right hand and wrist while doing light duty at work. The doctor noted that Petitioner has had carpal tunnel problems in the past for that wrist and has had a two-week history now of increasing pain and numbness.

On July 12, 2013, Petitioner underwent a right carpal tunnel release at Trinity Hospital. Dr. Sonnenberg performed the surgery.

Following the carpal tunnel surgery, Petitioner saw Dr. Sonnenberg on July 29, 2013. He recommended a home exercise program.

Petitioner next saw Dr. Sonnenberg on August 28, 2013. He noted that following the carpal tunnel surgery, "[t]he numbness is resolving very nicely." Dr. Sonnenberg also reviewed her chart and wrote, *inter alia*, the following:

> "On 11/5/12, the patient mentioned to me that she was having problems with numbness in her right hand. Our feeling, at that time, that it may be a postoperative carpal tunnel syndrome secondary to stress in her therapy program and rehabilitation of her right shoulder. On 11/26/12, she was seen once again in the office and she had symptoms related to carpal tunnel syndrome. I had felt, at that time, that this was probably related to use of her right hand in therapy while attempting to rehabilitate her right shoulder. I had no other causal basis to ascribe her carpal tunnel to at that point. She has no significant risk factors, such as diabetes, thyroid problems, kidney disease or rheumatoid arthritis. Her only significant risk factor was obesity.

*****

> The carpal tunnel injection did work and gave her relief for quite a while. She was eventually returned to light duty status at work as of March 2013. After one and a half months of light duty, she came back to my office on 5/1/13 complaining of increasing pain in her right hand after duty activities at work. She once again exhabited symptoms of carpal tunnel syndrome.
>
> *****
>
> The patient did not start to develop carpal tunnel symptoms until 4 months after her second shoulder surgery and 3 months after the commencement of physical therapy."

Petitioner's last visit with Dr. Sonnenberg was on October 9, 2013 at which time it was noted she was still having some difficulty with cramping in her right forearm muscles. He recommended an exercise program and authorized her off work until November 4, 2013.

Petitioner also testified that she returned to light-duty work on March 23, 2013. That light duty job involved her handing out equipment to the employees when they arrived and left for work. Petitioner testified she would have to reach up behind her and pick up with both hands the equipment she would have to give to each employee when they arrived for work. She had to give them flashlights, waist belts and leg chains. All of the equipment was stacked on shelves behind her. Petitioner testified that when the employees went out for break or lunch, they would have to turn in all of their equipment and she would have to put such equipment back on the shelves. When they returned from lunch or break, she would then have to turn around and reach up and give them back their equipment.

Petitioner testified that doing this continually all day long caused her to start noticing numbness and tingling in her right hand.

Petitioner also testified that she would have to answer the phone and take messages.

Petitioner testified she did return to full-duty work for Respondent.

She testified that, currently, she notices stiffness in her right shoulder and tingling in her right hand. On the date of the arbitration hearing, Petitioner testified that he right hand was numb.

CONCLUSIONS OF LAW

In support of his decision as to whether or not Petitioner's current condition of ill-being is causally related to this injury (F), the Arbitrator finds as follows:

Petitioner testified that on April 4, 2011, she sustained an injury to her right shoulder when she attempted to break up an altercation at work. She first saw Dr. Omerovic on the date of accident with head and neck complaints. On April 13, 2011, she complained to Dr. Omerovic of right shoulder pain. After an MRI and conservative treatment, Dr. Omerovic referred Petitioner to Dr. Sonnenberg, an orthopedic surgeon (Px.1). Dr. Sonnenberg examined Petitioner on August 1, 2011, reviewed the MRI which showed a definite tear of the rotator cuff and scheduled Petitioner for right shoulder surgery (Px.2).

Following the surgery, Petitioner continued to have problems with her right shoulder. Additional conservative treatment failed to relieve her of her shoulder problems. After undergoing a second right shoulder MRI, Dr. Sonnenberg recommended a second shoulder surgery which Petitioner underwent on June 26, 2012.

On August 15, 2012, Petitioner underwent a Section 12 examination with Dr. Nicholson, who confirmed that she sustained a right rotator cuff tear after a work-related altercation. He further opined that her condition was causally related to the accident and that she was not at MMI (Px. 9).

On November 5, 2012, Petitioner presented to Dr. Sonnenberg with complaints of right wrist numbness and tingling. Dr. Sonnenberg opined that Petitioner was developing signs of right carpal syndrome which may be post-operative carpal tunnel due to her aggressive therapy. The carpal tunnel was confirmed by way of an EMG/NCV. Dr. Sonnenberg then performed a right carpal tunnel release on Petitioner on July 12, 2013 (Px. 2).

On August 28, 2013, Dr. Sonnenberg again opined that, after reviewing Petitioner's chart, her carpal tunnel syndrome was probably related to the use of her right hand in therapy for the right shoulder (Px. 2).

Petitioner underwent a second Section 12 examination with Dr. Nicholson on March 13, 2013. Dr. Nicholson opined that Petitioner had a post-traumatic, work-related, rotator cuff tear with repair of the deltoid long head of the biceps (Px. 9).

Dr. Nicholson rendered no opinion as to the cause Petitioner's carpal tunnel syndrome.

The Arbitrator relies on the findings and opinions of Dr. Sonnenberg and Dr. Nicholson.

Based on the opinions of Dr. Sonnenberg and Dr. Nicholson, as well as the testimony of Petitioner as to the work activities she performed after returning to light-duty work in March 2013, the Arbitrator finds, by a preponderance of the weight of the evidence, that Petitioner's current conditions of ill-being of her right shoulder and right hand are causally related to the accident of April 4, 2011.

In support of his decision relating to whether medical services provided to Petitioner were reasonable and necessary and whether or not Respondent has paid all appropriate charges for those services, (J), the Arbitrator finds as follows:

Petitioner placed into evidence medical bills totaling $57,274.82. The Respondent placed into evidence a payment screen reflecting medical payments made to various providers.

From the Arbitrator's review of Respondent's Exhibit #1, it does appear that the Respondent did not pay any of the providers listed on Petitioner's Bills Exhibit List other than Trinity Hospital.

The Arbitrator, therefore, finds that all of the medical bills submitted into evidence by Petitioner are reasonable and necessary and that such bills were incurred as a result of treatment Petitioner received for her work-related injuries. Respondent is, therefore, liable for payment of these medical bills, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

The Arbitrator also notes that the parties made a statement on the record that Respondent would be given credit for any payments made to the providers on Petitioner's bills exhibit (Px. 8). In the event that there are some partial payments to providers other than Trinity Hospital, Respondent is to be given credit for those partial payments.

Petitioner also placed into evidence a medical bill from Glinda Fitzgerald, L.C.P.C., with a $0.00 balance, a bill from Christ Hospital with a balance of $845.00, and a bill from High Tech Medical Park with a balance of $950.00. Petitioner's group insurance carrier made payments on these bills. Yet, the Arbitrator finds that Respondent is liable for such bills. With respect to the bill from Glinda Fitzgerald, Petitioner made two $15.00 payments to Ms. Fitzgerald.

The parties agree that the Respondent is entitled to an 8(j) credit in the amount of $1,911.00 for the payments made on these three bills. Respondent will also hold Petitioner harmless for these payments.

The Arbitrator also awards Petitioner $30.00 for reimbursement to her for her co-pays.

In support of his decision as to the amount of temporary total disability benefits to which Petitioner is entitled, (K), the Arbitrator finds as follows:

Petitioner sought medical attention immediately after the accident on April 4, 2011 with Dr. Omerovic. Dr. Omerovic authorized Petitioner off work. Petitioner subsequently came under the care of Dr. Sonnenberg who also authorized Petitioner off work. Respondent's Section 12 examiner, Dr. Nicholson, confirmed that Petitioner should be off work for a period of time before returning to light-duty work.

Petitioner testified she did return to light-duty work on March 23, 2013.

There was a second period of temporary total disability for which Petitioner was off work following her carpal tunnel surgery. Based on the opinions of Dr. Sonnenberg, the Arbitrator finds that Petitioner was temporarily totally disabled during this period.

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from April 5, 2011 through March 22, 2013 and again from July 4, 2013 through November 3, 2013, a period of 120 weeks.

Petitioner testified that from April 5, 2011 through April 11, 2011, she was forced to take service-connected time off, which was her PTO time.

Petitioner also testified she received full salary for the period April 12, 2011 through April 12, 2012.

Respondent is entitled to a credit for the 52-3/7-week period during which Petitioner was paid her full salary or given extended benefits.

The Arbitrator lacks jurisdiction to order reinstatement of the 7 days of PTO time that Petitioner expended. However, the Arbitrator finds that Petitioner was clearly temporarily, totally disabled during these 7 days as a result of the April 4, 2011 accidental injury.

In support of his decision relating to the nature and extent of the injury (L), the Arbitrator finds as follows:

Petitioner underwent two surgeries to her right shoulder as a result of this accident. The first surgery involved an arthroscopic repair of the rotator cuff and subacromial decompression with debridement of the glenoid labrum. The second surgery involved arthroscopic excision of the os acromiale, a subacromial decompression and biceps tenodesis.

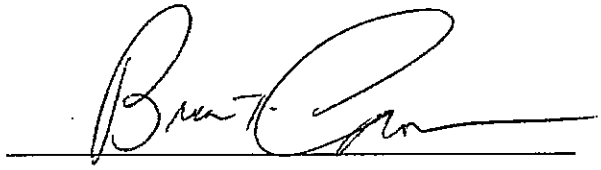
Petitioner also underwent a right carpal tunnel release.

Petitioner was released to return to full-duty work, effective November 4, 2013. She continues to perform full-duty work.

Petitioner testified that, currently, her right shoulder is still stiff, particularly when she wakes up in the morning. With regard to her right hand, Petitioner testified that it still tingles. Petitioner further testified that on the date of the arbitration hearing, her right hand was numb.

Petitioner last sought treatment for her right shoulder and her right hand on October 9, 2013.

Based on the foregoing, the Arbitrator finds that as a result of the accident of April 4, 2011, Petitioner sustained a loss of use, person as a whole, of 16.445%, pursuant to Section 8(d)2, and a loss of use of the right hand, of 15%, pursuant to Section 8(e)9 of the Act.



3/2/2015

Brian Cronin
Arbitrator

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Connie DeRousse,

Petitioner,

vs. NO: 14 WC 17509

St. Clair County,

Respondent.

16IWCC0443

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability and nature and extent, reverses the Decision of the Arbitrator and denies Petitioner's claim for compensation, for the reasons stated below.

Findings of Fact

Petitioner, a 60 year old finance/fiscal manager, testified that her job entails working on budgets, approving cash going in and going out of the agency and monitoring all grants. (T.9). She began working for Respondent in March of 1989. (T.10). She noted that she still works for the county. (T.10). She indicated that the steps she was injured on are ones that she has to traverse in order to go to and from a side of the building where they have quite a few programs. (T.10). Petitioner submitted two photos of the steps at PX5 while Respondent submitted eight (8) photos at RX1. Petitioner stands 5'7" and weighs 220 pounds. (T.25).

Petitioner testified that on the date of the alleged accident, 10/4/13, "[a]s she was coming down the steps [she] was thinking of other things, of what [she] was going over there for, not paying attention and [she] stepped down hard on that first step." (T.11-12). She agreed that she was walking up the longer stairway and then turned onto the short stairs. (T.11). Petitioner noted that she became unstable "... after the first step and on the second step is where [she] fell."

(T.12). She indicated that the step where she fell "... is not the same height as the steps that [she] was on previous" and that there's "... nothing to hold on to. There's a door that has a handle which looks like a rail but it actually collapses so that there's really nothing stable to hold on to." (T.14). She also noted that the step is shorter than normal steps and wider. (T.14). In addition, she estimated that she traverses these stairs on average ten (10) to fifteen (15) times a week. (T.16).

Petitioner testified that she was wearing tennis shoes at the time of the incident, which is what she normally wears to work on Fridays. (T.14). She noted that she "... actually caught [her]self as [she] was going down. And [she] do[es]n't actually remember if [she] went fully to the ground. [She] do[es]n't believe [she] did. [She] think[s] [she] caught [her]self ..." (T.15). Petitioner indicated that when she tried to get up she realized that she couldn't because of her knee. (T.15). She stated that she felt immediate pain and that "... it popped so loud that the people in the next hallway heard it." (T.15). However, she agreed that no one actually witnessed her fall. (T.15-16).

Petitioner indicated that she was seen immediately after her fall by the custodian, Dorian Young. (T.16). She noted that the secretary of the CD division "... put her in a chair so she could "... settle down, then somehow, you know, [she] hobbled back to [her] office where they told [her] that [she] needed to go to the emergency room." (T.16).

Petitioner subsequently visited St. Elizabeth's Urgent Care on the date of the incident. (T.17). A triage note contained in the St. Elizabeth's Hospital records dated 10/4/13 noted that the patient "twisted rt knee earlier today, stepped off a short step and heard and felt a pop." (PX1). An "Urgent Care Provider Note" from by Dr. Ellen Middendorf at this facility on the date in question recorded the following history: "Patient was walking down steps today at work. One of the steps was short, and she landed abruptly on her right foot. She felt and heard a pop in her right knee. Immediately, she was unable to bear weight. Since that time, the pain has improved minimally. She denies buckling or locking. Pain is worse if she tries to flex it. No treatment thus far. No numbness or paresthesias. No other joint pain." (PX1). The impression was "knee injury" with an additional impression of possible tibial avulsion fracture. (PX1). Petitioner was instructed to follow up with her physician or workers' compensation provider for further imaging, including an MRI. (PX1). She was also told to wear a knee immobilizer while mobile with crutches, no weight bearing and to ice areas of pain in 20 minute intervals. (PX1). Petitioner noted that she was then referred to an orthopedic surgeon. (T.17).

Petitioner visited Dr. Donald Bassman on 10/9/13. (T.18;PX2). Dr. Bassman ordered an MRI of her right knee and diagnosed a torn medial meniscus. (T.18). On 10/21/13 Dr. Bassman performed arthroscopic surgery in the form of a "... partial medial meniscectomy and debridement of degenerative joint disease of the medial femoral condyle." (PX2). Petitioner testified that following surgery she continued to have pain and swelling in the same spot on her right knee. (T.19). She received an injection which she noted lasted a short time only to have the pain and swelling return. (T.20).

Petitioner agreed that Dr. Bassman took her off work from 10/21/13 to 10/30/13. (T.18). She returned to work on 10/31/13. (T.19).

Petitioner testified that she currently experiences the same issues with pain and swelling. (T.20). She noted that she visited a new doctor and is on a three-month rotation of injections, noting that it has seemed to help but there is still pain. (T.21). She indicated that "[t]he pain is there a lot, especially going up and down stairs or things like that ..." (T.21). Petitioner denied ever having any of these problems prior to the fall on 10/4/13. (T.21).

Conclusions of Law

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered an injury which arose out of and in the course of his employment. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 203-204, 797 N.E.2d 665, 278 Ill.Dec. 70 (3003). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Commission*, 131 Ill.2d 478, 483, 546 N.E.2d 603, 137 Ill.Dec. 658 (1989).

"In the course of employment" refers to the time, place and circumstances surrounding the injury, meaning that, generally, the injury must occur within the time and space boundaries of the employment. *Sisbro*, 207 Ill.2d at 203. In this case, the claimant was working in the county building, going from one part of the building to another, at the time of her fall on October 4, 2013. Consequently, there is no dispute on the question of whether his injury occurred "in the course of" his employment.

The "arising out of" element is usually satisfied in the case of an unexplained fall. *Builders Square, Inc. v. Industrial Commission*, 339 Ill.App.3d 1006, 1010, 791 N.E.2d 1308, 274 Ill.Dec. 897 (2003). However, before this element is satisfied, an employee must put forth "evidence which supports a reasonable inference that the fall stemmed from a risk related to the employment." *Baldwin v. Workers' Compensation Commission*, 409 Ill.App.3d 472, 478, 949 N.E.2d 1151, 351 Ill.Dec. 56 (2011). Where an injury results from a risk to which the employee is exposed no more than the general public, the injury does not arise out of the employment. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill.2d 52, 59, 541 N.E.2d 665, 133 Ill.Dec. 454 (1989). Along these lines, it has been held that the act of traversing a flight of stairs does not expose a claimant to a greater risk of harm than that faced by the general public. See *Baldwin*, 409 Ill.App.3d at 478.

In the present case, Petitioner testified that "[a]s she was coming down the steps [she] was thinking of other things, of what [she] was going over there for, not paying attention and [she] stepped down hard on that first step." (T.11-12). She noted that she became unstable "... after the first step and on the second step is where [she] fell." (T.12). Petitioner indicated that the step where she fell "... is not the same height as the steps that [she] was on previous" and that there's "... nothing to hold on to. There's a door that has a handle which looks like a rail but it actually collapses so that there's really nothing stable to hold on to." (T.14). She also noted that the step is shorter than normal steps and wider. (T.14). In addition, she estimated that she traverses these stairs on average ten (10) to fifteen (15) times a week. (T.16).

The Commission notes that this fact scenario differs from the situation in *Village of Villa Park v. Illinois Workers' Compensation Commission*, 3 N.E.3d 885, 378 Ill.Dec. 320 (2nd Dist.

16IWCC0443

2013) wherein the claimant's previously injured knee "gave out" and he fell down about seven stairs, injuring both his right knee and lower back. *Village of Villa Park*, 3 N.E.3d at 887. In affirming the Commission's finding of causation as to the back, the court found that the claimant was "continually forced to use the stairway" a minimum of six times a day both for his personal comfort and "to complete his work related activities", that claimant's superiors were aware that he had an injured knee prior to the fall, and that "... the frequency with which the claimant was required to traverse the stairs constituted an increased risk on a quantitative basis from that to which the general public is exposed." *Village of Villa Park*, 3 N.E.3d at 891.

Here, Petitioner estimated that she traversed the steps in question only 10 to 15 times a week. She did not indicate that she was under any time constraints, or even that the fall was caused by some defect in the stairs, even though they were apparently smaller than usual. More to the point, she failed to provide any explanation whatsoever for her fall other than the fact that she was not paying attention to what she was doing.

More is required than simply showing that the stairs were irregular in size and shape, that there was no handrail to hold onto, or that she traversed the stairs in question approximately a dozen times a week. Indeed, Petitioner must show that something caused her to fall. Instead, Petitioner provided absolutely no explanation or reason for the fall, only that she was not paying attention and was "thinking of other things" as she was coming down the steps. Unfortunately, these circumstances do not present an increased risk of injury due to one's employment compared to members of the general public, and as such does not satisfy the exception to the general rule of noncompensability for injuries resulting from a personal risk.

Therefore, based on the above, and the record taken as a whole, the Commission finds that Petitioner failed to prove by a preponderance of the credible evidence that she sustained accidental injuries arising of her employment on October 4, 2013. As a result, the Arbitrator decision is reversed and Petitioner's claim for compensation is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award is vacated and Petitioner's claim for compensation is hereby denied.

DATED: JUN 3 0 2016
o: 2/22/16
TJT/pmo
51

Michael J. Brennan

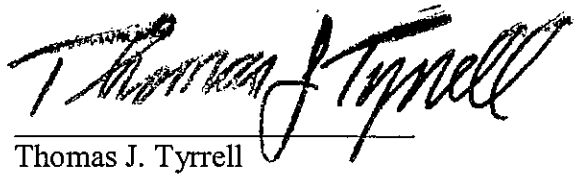
Kevin W. Lamborn

DISSENT **16IWCC0443**

I dissent. This case involves an unexplained fall that provides similar evidence of an increased risk of injury due to one's employment, both on a quantitative and qualitative basis, as that found in *Village of Villa Park*, supra -- the very case the majority attempts to distinguish.

In this case, Petitioner's unrebutted and credible testimony shows that as part of her employment duties she was forced to walk between various parts of Respondent's building, and that during the course of these travails she was required to navigate some rather tricky and unusual stairs – ones that the photos show involve going up a longer flight of seven (7) stairs only to turn the corner on a landing and step down two narrow and awkward steps, with no railing or other assistive device to hold onto. That's where and how Petitioner says she fell, and she, not members of the general public, had to do that ten to fifteen times a week. To say that this was somehow not frequent or hazardous enough, as the majority seems to infer, simply flies in the face of reason. And to find that there was no increased risk of injury under these circumstances, and then to deny compensation based on Petitioner's perceived failure to "explain" her "unexplained" fall, is simply not supported by the law and facts of the case.

For that reason, I would affirm the Arbitrator's well-reasoned and thoughtful decision and find that Petitioner proved by a preponderance of the credible evidence that she was exposed to an increased risk of injury as a result of her employment activities, and that as a result she sustained accidental injuries arising out of and in the course of her employment on October 4, 2013.



Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DeROUSSE, CONNIE
Employee/Petitioner

Case# **14WC017509**

ST CLAIR COUNTY
Employer/Respondent

16IWCC0443

On 8/11/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% 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:

1239 KOLKER LAW OFFICES PC
JASON R CARAWAY
9423 W MAIN ST
BELLEVILLE, IL 62223

0180 EVANS & DIXON LLC
MARILYN C PHILLIPS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

16IWCC0443

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

Connie DeRousse
Employee/Petitioner

v.

St. Clair County
Employer/Respondent

Case # **14** WC **17509**

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **6/19/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **10/4/13**, 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 $**68,913.59**; the average weekly wage was $**1,325.26**.

On the date of accident, Petitioner was **60** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $883.41/week for 1 2/7 weeks, commencing 10/21/13 through 10/30/13, as provided in Section 8(b) of the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the right leg pursuant to §8(e) of the Act.

Respondent shall pay reasonable and necessary medical services provided in Petitioner's Exhibit 6, as provided in Section 8(a) and 8.2 of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

8/3/15
Date

AUG 11 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION

CONNIE DEROUSSE,	)	
	)	
Petitioner,	)	14 WC 17509
	)	
v.	)	Arb. Edward Lee
	)	
ST. CLAIR COUNTY,	)	
	)	
Respondent.	)	

MEMORANDUM OF DECISION OF THE ARBITRATOR

FINDINGS OF FACT

On October 4, 2013 Petitioner was employed by Respondent as the Finance Manager for St. Clair County. Petitioner began working for the County in 1989. On the date in question, Petitioner was walking through her department and encountered a small flight of stairs. Prior to the fall, Petitioner had traversed these stairs on a number of occasions. Petitioner testified that on average she traversed this short flight of stairs ten to fifteen times per week.

The fall occurred when Petitioner stepped down off the landing of the short flight of stairs onto the first step. Petitioner was wearing tennis shoes at the time of her fall. As seen and marked in Respondent's Exhibit 1-G, the steps in question are not normal sized steps. In addition, there are no hand rails of any kind to utilize while traversing the stairs. As Petitioner began to fall, she attempted to catch herself from completely falling to the floor. Petitioner felt immediate pain in her right knee and heard a loud popping sound. Immediately after the fall, Petitioner was assisted to a chair and was told to go to an emergency room.

Petitioner presented on the day of accident to St. Elizabeth's Urgent Care. (PX. 1) There she gave a consistent history of mechanism of her injury, namely that she twisted her right knee while stepping off a short step hearing a loud pop. (Id.) She was diagnosed with a right knee injury including a possible tibial avulsion fracture. She was given Motrin as well as crutches and was instructed to follow up with a primary care physician.

Petitioner next presented to Dr. Bassman on October 9, 2013. (PX. 2) She presented with severe pain to the right knee. Upon physical examination, Dr. Bassman noted crepitation and tenderness of the right knee. Dr. Bassman ordered and MRI of the right knee which revealed a non-displaced tear of the body and posterior horn of the medial meniscus. (PX. 2 & 3) On October 21, 2013 Dr. Bassman performed an arthroscopy of the right knee with a partial medial meniscectomy and debridement of the medial femoral condyle. (PX. 2 & 4) Dr. Bassman took Petitioner off work after the surgery through October 30, 2013. Petitioner returned to work as scheduled.

Petitioner however continued to experience pain in the right knee post-operatively. On March 12, 2014 she returned to see Dr. Bassman. She presented with continued pain and swelling. Dr. Bassman then performed a kenalog injection into the right knee. (PX. 2) However, Petitioner continued to experience pain and swelling after the injection. She returned to Dr. Bassman on November 18, 2014. At this time she presented with 5/6 out of 10 pain as well as a feeling of weakness in her right knee. Upon physical examination, Petitioner did not evidence full range of motion in her right knee.

Petitioner testified that her right knee continues be problematic. She testified that she still has pain and swelling and had neither problem prior to her fall on October 4, 2013. Petitioner has been able to continue to work as the Finance Manager for the County.

CONCLUSIONS OF LAW

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner's accident while traversing stairs at work on October 4, 2013 arose out of and in the course of her employment by Respondent. While the Arbitrator notes that simply falling at work on stairs does not in and of itself in isolation indicate a finding of an accident arising out of one's employment, it is well settled that if some factor regarding the traversing of the stairs increases a Petitioner's risk of injury over that of the general public, such fall does arise out of and in the course of employment.

In the instant case it is clear the stairs in question did pose a greater risk to the Petitioner than the general public. It is undisputed that the steps in question are irregularly small in height without any hand rail present to assist an individual in traversing the stairs. Further, it is well established that a neutral, normally non-compensable risk, such as traversing stairs, can create an injury arising out of employment if such neutral risk is encountered by the Petitioner more frequently than the general public. The Arbitrator further finds Petitioner's testimony of traversing these irregular stairs 10-15 times per week an activity Petitioner performed more frequently than the general public.

As there is no dispute that Petitioner was in the course of her employment at the time of the fall, the Arbitrator concludes, based upon the totality of the photographic evidence and testimony, that Petitioner's fall and subsequent injuries arose out of and in the course of her employment.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECCESARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

The Arbitrator finds the entirety of Petitioner's short course of medical and surgical treatment to be reasonable and necessary as related to her fall. Petitioner immediately presented for treatment which led to an MRI indicating a meniscal tear and surgery less than a month after her fall. Further, Respondent presented no testimony to dispute the causal connections found in the medical records submitted by Petitioner at hearing. As such, Respondent shall pay in accordance with the appropriate medical fee schedule the bills associated with her treatment contained in Petitioner's Exhibit 6.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The Arbitrator finds Petitioner's short course of missed work authored by Dr. Bassman to be causally connected, reasonable and necessary. As such, Respondent shall pay Petitioner 1 2/7 weeks of TTD covering the time period of 10/20/13 through 10/30/13.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Pursuant to 8.1b of the Act in determining the level of permanent partial disability, the Arbitrator has considered the following factors:

(i) That no AMA impairment rating was submitted,

(ii) That the Petitioner was employed as a Finance Manager for the Respondent both before and after her accident and treatment.
(iii) That Petitioner was 60 years of age at the time of her injury,
(iv) That the Petitioner's future earning capacity was not affected by her injury,
(v) That the Petitioner's account of her symptoms and treatment is corroborated by the medical records and indicates a good recovery.

Based on the above factors, the Arbitrator finds Petitioner sustained a 15% loss of use of the right leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darwin Kirkman,

Petitioner,

vs.

NO: 14 WC 27275

16IWCC0444

CTA,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, penalties and nature and extent, reverses the Decision of the Arbitrator and denies Petitioner's claim for compensation, for the reasons stated below.

Findings of Fact

Petitioner, a 42 year old right-hand dominant bus driver, testified that on 8/4/14 "... the bus was standing in traffic. [He] was sitting like about a block and a half right before Kedzie when [he] heard a loud bang and bus movement. And [he] reacted with a quick right turn and kind of hurt [his] neck and [his] thumb that was caught in the spoke of the steering wheel." (T.9). He noted that he turned his "... neck and [his] body, and [his] hands were attached to the steering wheel. [He] made a right turn looking at what had hit the bus." (T.9). With respect to his hand, Petitioner testified that "[i]t got caught in the steering wheel. [He] guess[ed] the steering wheel has a cross on it, and [his] thumb got caught in between the cross as [he] was turning; and [he] kind of hurt [his] neck a bit from the reaction." (T.9-10). He noted that it was his right thumb that got caught. (T.10). He went on to state that "[i]t was real quick, sudden. The impact – this caught [him] off guard. It wasn't the impact itself. It was just the accident itself that hit the bus, and [he] reacted." (T.10).

On cross examination, Petitioner indicated that the bus was stopped at the time of the incident and that the contact with the other vehicle occurred on the right middle side of the bus, while the driver's seat is in the left front portion. (T.23-24). He also reiterated that he felt pain as he turned his head to the right in reaction to the impact. (T.24). He noted that he believed there were about three passengers onboard at the time and that none of them were taken away by ambulance. (T.25). Furthermore, while he wasn't there when the bus was removed, to his knowledge it was driven away. (T.25). He also agreed that following the incident he completed injury-on-duty paperwork. (T.26).

In an "Employee's Report of Injury on Duty" dated 8/4/14 it was noted that Petitioner suffered an injury on that date involving "neck, stress" and that before the injury he was "sitting, vehicle sitting." (RX2).

Petitioner noted that following the incident "[his] neck was sore. [He] didn't discover that [his] thumb was hurt until the next day. It was swollen." (T.10). He indicated that an ambulance subsequently arrived on the scene and he was told to lie down on a stretcher before being taken to Little Company of Mary Hospital. (T.11).

A Chicago Fire Department report dated 8/4/14 recorded a complaint of "neck hurts" and noted that "[u]pon arrival pt found on board with c-collar in car of CFD T45. Pt c/o neck pain. Pt. denies LOC, head, or back pain..." (PX1). The impression was "neck pain." (PX1).

The records of Little Company of Mary Hospital dated 8/4/14 contains the following history: "42-year-old male comes into the ED complaining of being involved in a motor vehicle accident, patient complains of neck pain, patient is a bus driver and was involved in a low impact the [sic] accident approximately one hour prior to arrival, patient was ambulatory on the scene, place on c-collar and backboard, patient at that time was brought into the ED for evaluation he denies any alcohol intoxication he denies any distracting injuries, no headache nausea vomiting anticoagulation use. Complains of only pain in neck, 2/10 nonradiating." (PX1). When asked why he did not say anything about his right thumb while he was at the hospital on the day of the incident, Petitioner testified that he "... was kind of in shock pretty much." (T.12). X-rays of the cervical spine taken at the time of this visit revealed no fracture or subluxation and Petitioner was discharged with a diagnosis of acute cervical strain. (PX1).

Petitioner visited his primary care physician, Dr. Roy Lacey, on 8/6/14 at which time he told him that he had pain in his thumb. (T.12). Dr. Lacey in turn referred him to Dr. Basel Al-Aswad at Evergreen Orthopedics. (T.13). It does not appear that the records of Dr. Lacey were submitted into evidence.

Petitioner visited Dr. Al-Aswad on 8/14/14. In an office note on that date, Dr. Al-Aswad recorded the following history: "This 42 year old male is here for evaluation of his right thumb. He states that he has had an injury 30 years ago to his hand and thumb and has had some problems with it on and off over the years but is quite vague about how symptomatic he was. He had an injury about 10 days ago on 8/4/14 when he was involved in an accident as he was driving his CTA bus. The patient started having pain and swelling and an obvious deformity and he had difficulty as well as in the area of the thumb at the base of the metacarpophalangeal joint.

He also had difficulty opening up jars and with flicking of the lighter with his right thumb. The patient is right handed. He was seen at another clinic and x-rayed and was told that it was negative." (PX2). Following his examination, Dr. Al-Aswad's impression was torn collateral ligaments right thumb, ulnar and possibly radial. (PX2).

An MRI of the right thumb performed on 8/14/14 was interpreted as evidencing 1) low-grade sprain of the ulnar collateral ligament of the thumb suspected; 2) small effusion of the first MCP joint. (PX2).

Petitioner testified that he thereupon returned to work as a bus operator performing the same duties for the same pay for Respondent on 8/15/14 "[b]ecause [his] claim was denied, and [he] had to pay [his] mortgage." (T.13,26).

Petitioner testified that he returned to Dr. Al-Aswad on 8/18/14 at which time the latter reviewed the MRI and discussed potential surgery for a possible torn ligament in his right hand. (T.14). In his office note dated 8/18/14, Dr. Al-Aswad noted that the MRI "demonstrates a low grade sprain of the ulnar collateral ligament with a small effusion." (PX2). However, Dr. Al-Aswad's impression was "[a] torn ulnar collateral ligament right thumb", noting that he was "... not very impressed with the MRI and ... [was] not sure if we can make a clinical decision based on it. However, I do think that this patient will have to decide if he is symptomatic enough to justify surgical intervention and would need a reconstruction and therefore he would need to see a hand surgeon." (PX2).

Petitioner testified that Dr. Al-Aswad told him to remain off work "... but [Petitioner] couldn't do it. [He] had to work." (T.14). He noted that Dr. Al-Aswad thereupon referred him to a hand specialist, Dr. William Baylis at Parkview Orthopedics. (T.14).

Petitioner visited Dr. Baylis on 1/2/15 at which time he recorded that on 8/4/14 Petitioner was a bus driver and that his bus was hit "... on the driver's side in the middle of the bus. A car hit the bus, but this bus was stopped. He said maybe he might have hit his thumb against the wheel... He has actually claimed this as Workman's Comp but it was denied. He has been seen by Dr. Al-Aswad who got an MRI of his thumb on 08/14/2014 that showed a mild ulnar collateral ligament sprain with no evidence of radial collateral ligament injury or fracture or contusion. Apparently 30 years ago he hurt that thumb playing basketball. He never had many issues but always noticed a bit of a lump over the dorsoradial aspect of the metacarpophalangeal joint..." (PX5). Following his examination, Dr. Baylis noted that "[t]o me he has an old radial collateral ligament injury to his right thumb, and I think there may have been slight exacerbation with the bus injury, yet it is sort of funny that he was not even moving and he was hit on the side how much force that can put to his thumb is always unknown." (PX5).

Dr. Baylis concluded by stating that "[a]t this point other than weakness he has no pain and he is able to work. He takes nothing for it and does not require a brace. I would just watch this, observe it. I think he should function just fine. Should he have increasing symptoms of pain and/or instability, that may require a fusion at a later date. At this point I would recommend no bracing, no therapy. He seems to be function well. He is okay for full duty. We will see him back as needed." (PX5).

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Petitioner testified that he has not had any further treatment for his right thumb since his visit to Dr. Baylis on 1/2/15, nor does he have any appointments scheduled for treatment pertaining to anything from this incident. (T.15,26). He agreed that he "[p]retty much" remained off work from 8/5/14 through 8/14/14 and that he never received any workers' compensation benefits; instead, his claim was denied and he received sick pay. (T.20). He also indicated that to the best of his knowledge none of his bills were paid by workers' comp; instead, he paid certain deductibles and put the bills through his group. (T.22).

Petitioner testified that prior to the date of the alleged accident he was not having any problems with his neck and that following the incident he noticed that his neck was a little sore for about three days. (T.15). He also noted that prior to the alleged accident he was not having any problems with his right thumb, and that currently he notices that "[t]he confidence isn't there anymore. [He] can't grip as much when [he] use[s] [his] lawn mower and [his] snowblower. The more [he] use[s] it, the pain kind of intensifies, the longer [he] use[s] it." (T.15-16). He indicated that he uses Ibuprofen to treat the pain in his thumb and that he notices that his right thumb "protrudes out" now compared to before the accident. (T.16).

Petitioner is still currently working for Respondent as a bus operator. (T.17). He indicated that he notices pain while performing his duties, including straightening out the mirror and picking up paper. (T.18). He noted that he has to "... grip the wheel probably like eight hours a day; and [he] get[s] home, you know, [he] can feel the pain. (T.18).

Conclusions of Law

The burden is on the party seeking an award to prove by a preponderance of credible evidence the elements of his claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d. 236, 369 N.E.2d 853, 12 Ill.Dec. 146 (1977).

In the present case, Petitioner testified that on 8/4/14 "... the bus was standing in traffic. [He] was sitting like about a block and a half right before Kedzie when [he] heard a loud bang and bus movement. And [he] reacted with a quick right turn and kind of hurt [his] neck and [his] thumb that was caught in the spoke of the steering wheel." (T.9).

In an "Employee's Report of Injury on Duty" dated 8/4/14 it was noted that Petitioner suffered an injury on that date involving "neck, stress" and that before the injury he was "sitting, vehicle sitting." (RX2). No mention of any right thumb injury is made in this report. Likewise, no complaints relative to his right thumb were noted in the Chicago Fire Department report dated 8/4/14 wherein it was noted that Petitioner complained that his "neck hurts" and that "[u]pon arrival pt found on board with c-collar in car of CFD T45. Pt c/o neck pain. Pt. denies LOC, head, or back pain..." (PX1). The impression was "neck pain." (PX1). Furthermore, the records of Little Company of Mary Hospital dated 8/4/14 reference only complaints of neck pain following a low impact accident. (PX1). When asked why he did not say anything about his right thumb while he was at the hospital on the day of the incident, Petitioner testified that he "... was kind of in shock pretty much." (T.12).

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The Commission notes that the video footage submitted into evidence by Respondent at RX1 clearly shows, in one of the exterior views, a vehicle backing up alongside the stationary bus allegedly driven by Petitioner. As the vehicle attempts to slowly back around an adjacent street corner, after apparently being hemmed in by the bus, the front left edge of the vehicle on the driver's side is seen striking the right midsection of the bus, crushing the left headlight. In sharp contrast, the bus does not appear to move or shake in any way based on the views provided by both the exterior and interior cameras. Furthermore, there does not appear to be any immediate reaction by the passengers inside the bus immediately following accident. And while there is no camera angle showing the driver's seat area, it would be hard to imagine that anyone inside the bus, including the bus driver, would have suffered the type of injuries alleged by Petitioner based on such a minor traffic incident – namely, injuring his neck by turning quickly at the sound and getting his right thumb caught in the spoke of the wheel.

Furthermore, Petitioner's behavior following the incident, as seen sporadically in the video, of someone walking around showing little of no signs of injury, speaks to the true severity of the incident. In addition, Petitioner's claim that he did not mention the injury to his thumb to hospital personnel because he was "kind of in shock pretty much" is likewise difficult to reconcile with what is shown in the video. Indeed, one would have to question whether anyone involved in the incident, from the driver of the other vehicle to the passengers in the bus, could have possibly suffered any significant injury as a result of what can only be described as a minor motor vehicle accident.

Therefore, based on the above, and the record taken as a whole, the Commission reverses the decision of the Arbitrator and finds that Petitioner failed to prove by a preponderance of the credible evidence that his current conditions of ill-being relative to his neck and right thumb were causally related to the incident on 8/4/14. Accordingly, Petitioner's claim for compensation is hereby denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award is vacated and Petitioner's claim for compensation is hereby denied.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 3 0 2016
TJT/pmo
o: 5/10/16
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Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pedro Velez,

Petitioner,

vs. NO: 10 WC 25582

Caterpillar, Inc.,

Respondent.

16IWCC0445

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability and Petitioner's wage rate, 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.

For the reasons set forth below, the Commission modifies the Arbitrator's decision by vacating the award of temporary partial disability and awarding temporary total disability to Petitioner from January 3, 2011 through June 20, 2011. The Commission finds that Petitioner was at maximum medical improvement (MMI) and was capable of returning to work on a full-duty basis by June 20, 2011. Furthermore, the Commission finds that the income the Petitioner received from his secondary employment should not be included in the calculation of his average weekly wage.

The Petitioner was discharged from physical therapy on June 20, 2011. (Rx1) The Petitioner failed to provide any evidence of following up with his treating physician (with the exception of his discharge note from December 11, 2012) pursuant to his May 27, 2011 examination with his treating physician. Moreover, Petitioner failed to provide evidence of treatment with any other physician prior to his treating physician's discharge note dated December 11, 2012. (Px5)

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Per the IWCC Request for Hearing form, the Petitioner's average weekly wage is annotated as $936.38 and agreed to by both parties. Although the Petitioner worked as an independent contractor for a secondary employer during the time of Petitioner's accident, his income received from his work with the secondary employer should not be included in the calculation of his average weekly wage. Section 10 of the Act reads: "When the employee is working concurrently with two or more employers and the respondent employer has knowledge of such employment prior to the injury, his wages from all such employers shall be considered as if earned from the employer liable for compensation." There is no evidence in the record as to whether the Respondent was aware of Petitioner's secondary employment prior to his injury. Therefore, the Commission finds that the parties' agreed upon amount of $936.38 is the appropriate average weekly wage.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $624.25 per week for a period of 24.14 weeks, from January 3, 2011 through June 20, 2011, 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 $561.83 per week for a period of 137.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 27.5% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of temporary partial disability is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the average weekly wage of Petitioner is $936.38

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 $45,000.00. 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: JUN 3 0 2016

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

TJT/gaf
O: 5/9/16
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VELEZ, PEDRO
Employee/Petitioner

Case# **10WC025582**

CATERPILLAR INC
Employer/Respondent

16IWCC0445

On 1/21/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

3029 FICHERA & MILLER PC
HOWARD MILLER
415 N LASALLE ST SUITE 301
CHICAGO, IL 60654

2851 CATERPILLAR INC
ELIZABETH Z LeBARON
PO BOX 348 A-11
AURORA, IL 60507

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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☐ 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 VELEZ
Employee/Petitioner

v.

CATERPILLAR INC.
Employer/Respondent

Case # **10** WC **25582**

Setting: **Geneva**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **December 11, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

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FINDINGS

On **October 1, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**48,691.76**; the average weekly wage was $**938.38**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**47,483.06** for TPD, for a total credit of $**47,483.06**.

ORDER

Respondent shall be given a credit of $**47,483.06** for TPD for a total credit of $**47,483.06**.

Respondent shall pay Petitioner temporary partial disability benefits of $**610.08**/week for **48 4/7** weeks, commencing **01/03/11** through **12/08/11**, as provided in Section 8(a) of the Act. Respondent shall be given a credit against PPD in the amount of $**17,850.86** representing over paid TPD.

Respondent shall pay Petitioner permanent partial disability benefits of $**561.83** /week for **137.5** weeks, because the injuries sustained caused the **27.5%** 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

1/20/15
Date

JAN 21 2015

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FINDINGS OF FACT

This case involves a Petitioner alleging an injury while working for the Respondent on October 1. 2008. There is no dispute with regard to the Petitioner's accident. The only issues in dispute are: 1) TTD/TPD from January 3, 2011 through December 12, 2012; and 2) the nature and extent of the Petitioner's injuries.

Petitioner Pedro J. Velez testified that he currently resides in Chicago and works as an independent contractor for Century 21. Petitioner stated that he is a Realtor/Broker who brings buyers and sellers together. He has worked for Century 21 continuously from 2006 to the present.

On October 1, 2008, Petitioner was also employed as a maintenance electrician at Respondent's Aurora facility. On that date, he was using a "hot stick" to restore power to an overhead hoist. Petitioner described the hot stick as a long pole, which will reach 50 feet to the ceiling. He stated that he struggled with the stick and lost control. As it was falling, he felt a sharp pain in his neck. When he performed his next job, he continued to feel excruciating pain; he told his supervisor and reported to medical.

Petitioner stated that he was seen at Respondent's medical department where he was given pain killers and sent by ambulance to Rush Copley hospital. Petitioner was experiencing sharp pain in his neck down his left arm. At the emergency room, he was given x-rays and pain medication. Petitioner stated that he was followed by Dr. Roggenkamp at Respondent's medical department, who referred him to Dr. McGivney at Castle Orthopedics. Dr. McGivney ordered physical therapy, which Petitioner believed was performed at ATI in Chicago. Petitioner stated that therapy did not improve his condition and Dr. McGivney recommended surgery.

Petitioner transferred his care to Dr. Espinoza. He was still experiencing neck pain and Dr. Espinoza recommended surgery. In October 2010, Dr. Espinoza performed a C5-C7 fusion with hardware. Following surgery, Petitioner testified that he felt a lot better. He was released by Dr. Espinoza on December 12, 2012. Petitioner stated that his employment with Respondent ended in March 2011 and he has never returned to work for Respondent. Petitioner testified that he did not perform any work for Century 21 between October 1, 2008 and December 12, 2012, although he volunteered that he received checks during this time period for prior work. Petitioner stated that he no longer participates in strenuous sports such as basketball, running, or baseball because those activities create a strain on his neck. He did not testify to any other change in his activities or physical condition from the October 1, 2008 incident.

On cross-examination, Petitioner admitted that he has not seen a doctor for his cervical spine since December 12, 2012. He also admitted that he does not take any prescription medication for his cervical spine condition. Petitioner did not recall attending a work conditioning evaluation on October 4, 2012 and he did not recall that the therapist did not recommend work conditioning because Petitioner was able to perform his essential job duties. Petitioner did recall participating in the valid October 24, 2012 functional capacity evaluation which placed him at a very heavy physical demand level.

Petitioner did not recall that he failed to attend a scheduled independent medical evaluation scheduled with Dr. Steven Mather in July 2011.

Petitioner was asked whether he was performing training or desk work at Century 21 by January 31, 2011 but could not recall. He did not recall receiving a check in the amount of $15,071.42 for temporary partial disability

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covering the period from January 3, 2011 through June 20, 2011. He also did not recall a second payment in the amount of $32,411.64 for temporary partial disability for the period from June 21, 2011 through July 13. 2012. Petitioner did recall receiving unemployment benefits from June 19, 2011 through December 17. 2011. He admitted that he certified to the State of Illinois that he was physically able to work when he applied for those benefits. On re-direct examination, he explained that unemployment was his only source of income.

Respondent's medical records show that on October 1, 2008, Petitioner reported that he injured his neck and shoulder using a hot stick to restore power. He was transported to the Copley Hospital emergency room, where he was diagnosed with cervical radiculopathy and released to restricted work. The following day, he was examined by Dr. Roggenkamp (Caterpillar occupational health), who assessed acute onset of left neck and arm pain with significant cervical degenerative joint disease. When he failed to improve, Dr. Roggenkamp ordered a cervical MRI. The October 7, 2008 MRI showed significant disc bulge and osteophyte complexes at C3-4, C5-6 and C6-7. Dr. Roggenkamp then referred him to Dr. Thomas McGivney at Castle Orthopedics. (PX 3)

Petitioner saw Dr. McGivney on October 15, 2008. Dr. McGivney diagnosed cervical spondylosis with disk herniation with cervical radiculitis. Dr. McGivney took him off work and two weeks later, he prescribed physical therapy. (PX 3, PX 4) Petitioner attended five sessions of physical therapy at ATI between October 30 and November 7, 2008. On November 10, 2008, Petitioner returned to light duty work. At a December 8, 2008 visit, Petitioner told Dr. McGivney that he was doing better and Dr. McGivney wrote restrictions. (PX 3)

In March 2010, Petitioner saw Dr. Roggenkamp for a restriction review. At that time, he seemed to be getting along very well and Dr. Roggenkamp did not believe that he required any significant treatment. Dr. Rogenkamp renewed his restrictions of no lift over 35 pounds, not push/pull over 40 pounds and no overhead work. Petitioner returned two weeks later with the names of two chiropractors he wanted to see, but Dr. Roggenkamp recommended treatment with a spine surgeon over chiropractic treatment. He ordered a follow up cervical MRI. The May 15, 2010 scan did not show any significant changes from the prior study. Dr. Roggenkamp referred Petitioner back to Dr. McGivney, who discussed an anterior cervical fusion. Instead, Petitioner chose to treat with a chiropractor, Dr. Lindstrom.

On July 21, 2010, Petitioner chose to see Dr. Francisco Espinoza (Neurological Surgery & Spine Surgery, S.C.) for an initial consultation. Dr. Espinoza reviewed the MRI films which showed herniations and significant stenosis at C5-6 and C6-7. He recommended an anterior cervical discectomy and fusion at those levels. which was performed on October 21 2010.

At a follow up appointment on November 5, 2010, Petitioner reported that he was doing well and that his left arm symptoms had essentially resolved. Dr. Espinoza recommended that he discontinue his cervical collar except for driving. On December 3, 2010, Petitioner continued to do well; x-rays showed good progress of the fusion and Dr. Espinoza again recommended that Petitioner wean from the use of the cervical collar. A March 4, 2011 CT scan showed the fusion to be maturing appropriately with no evidence of pseudoarthrosis or instrument failure. Petitioner was scheduled for sinus surgery and Dr. Espinoza stated that he could begin physical therapy when cleared by his ENT surgeon.

On March 18, 2011, Petitioner was cleared to begin four weeks of physical therapy followed by four weeks of work conditioning. Dr. Espinoza stated that Petitioner would not be ready to return to work until after four to five weeks of physical therapy followed by four weeks of work conditioning. He anticipated that Petitioner

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would reach MMI about six to seven months after the date of surgery, which would be some time after April 21, 2011. On April 15, 2011, Petitioner was six months post fusion; he was participating in therapy and no longer required pain medications. On May 27, 2011, Dr. Espinoza recommended that Petitioner complete his therapy. At this appointment, Dr. Espinoza did not discuss Petitioner's work status or further treatment recommendations. (PX 1A)

Petitioner also offered a form letter dated December 11, 2012 stating that Petitioner had reached MMI and could return to work with no restrictions. Petitioner did not offer any treatment notes from Dr. Espinoza after May 27, 2011. Respondent's payment history shows that Petitioner apparently attended 32 physical therapy sessions between March 23, 2011 and June 20, 2011. (RX 2) No therapy treatment notes were submitted at hearing.

On December 2, 2011, Dr. Jesse Butler (Spine Consultants Park Ridge) reviewed Petitioner's treatment records from the initial date of accident through Petitioner's discharge from physical therapy on June 20, 2011. Dr. Butler also reviewed a November 14, 2011 CT of the cervical spine, which revealed a complete osseous fusion of C5 through C7. Dr. Butler opined that Petitioner did not require any additional physical therapy, work conditioning or other medical treatment. He further stated that Petitioner could perform unrestricted full duty work. (RX 1)

A work conditioning evaluation performed on October 4, 2012 demonstrated that Petitioner had the physical capabilities to perform all essential job functions of an electrician and did NOT recommend work conditioning. (RX 6, emphasis added.) An October 24, 2012 Functional Capacity Evaluation demonstrated that Petitioner had the physical capabilities to function at the very heavy physical demand category of work. (RX 7)

Records also demonstrate that Petitioner was an independent Salesperson associated with Century 21 Salamanca continuously from October 4, 2006 through at least September 7, 2012. During 2010 and 2011, Petitioner earned commission income from the sale of five properties. (RX 4, RX 5)

CONCLUSIONS OF LAW

1. With regard to the issue of TTD, the Arbitrator finds that the Petitioner is entitled to Temporary Partial Disability (TPD) benefits from January 3, 2011 through December 8, 2011. In support of this finding, the Arbitrator relies on the medical evidence, particularly the report from Dr. Butler and the Petitioner's own medical records. The Arbitrator notes that Dr. Espinoza anticipated that Petitioner would reach maximum medical improvement after he completed physical therapy, six to seven months following surgery. His anticipated MMI date was April 21, 2011. On May 27, 2011, the final office visit submitted by Petitioner, Dr. Espinoza reported that Petitioner felt significant improvement and that he was doing well. He recommended that Petitioner finish his remaining sessions of physical therapy. Petitioner was discharged from physical therapy on June 20, 2011. Petitioner did not offer his therapy notes into evidence and did not offer any further office notes from Dr. Espinoza. To further complicate matters, Petitioner failed to attend an independent medical examination scheduled with Dr. Steven Mather in July 2011.

In December 2011, Dr. Jesse Butler performed a record review of Petitioner's entire medical chart, including his physical therapy records and November 14, 2011 CT scan. On December 8, 2011, Dr. Butler opined that Petitioner had reached maximum medical improvement for his cervical injury. Dr. Butler relied on the June 20, 2011 discharge from physical therapy and the November 14th CT scan showing a complete fusion. Dr. Butler

further opined that Petitioner did not require any medical treatment, including work conditioning, and was able to work a full duty, unrestricted job as an electrician. Dr. Butler's opinion that Petitioner could work a full duty job is supported by Petitioner's own conduct showing that he could work after June 20, 2011. First, the Century 21 records show that Petitioner was successfully working: he entered into sales contracts on September 9, 2011 and November 15, 2011. Further, he first certified to the State of Illinois that he was able to work around the time he completed physical therapy (first unemployment benefit was June 19, 2011). He stopped unemployment benefits on December 17, 2011 (around the time of Dr. Butler's opinion), which again suggests that he had returned to full time employment. (RX 3)

The only other medical records submitted after the final appointment with Dr. Espinoza on May 27, 2011 also support Dr. Butler. On October 4, 2012, Accelerated Rehabilitation determined that Petitioner did not require work conditioning because he was already physically able to perform all aspects of his job duties as an electrician. A valid functional capacity evaluation performed on October 24, 2012 found that Petitioner was able to function at the very heavy physical demand category of work. Finally, the form letter dated December 11, 2012 from Dr. Espinoza's office indicated that he was at maximum medical improvement and did not require any work restrictions.

Petitioner did not submit his physical therapy discharge note from June 20, 2011 (which may have shown that he was able to perform the essential job duties of an electrician) and did not submit any treatment records from Dr. Espinoza after May 27, 2011. In the absence of records showing that Petitioner was disabled from performing his job duties as an electrician, the Arbitrator relies upon Dr. Butler and finds that Petitioner was at maximum medical improvement on December 8, 2011 and further finds that he was able to perform his full duty job as an electrician.

The undisputed evidence also shows that Petitioner was continuously employed as a real estate salesperson/broker from 2006 through the date of hearing and earned income from that employment. Therefore, the Arbitrator finds that Petitioner is entitled to temporary partial disability and is not entitled to temporary total disability. Records from Century 21 Salmanca show that Petitioner earned $8,631 in calendar year 2010; $1,139.28 in 2011 and at least $1,141.20 through September 7, 2012. The only evidence of Petitioner's earnings in the full performance of his job as an electrician is his agreed average weekly wage of $936.38. (AX 1) The Arbitrator computes Petitioner's temporary partial disability for 2011as follows: $936.38 less Petitioner's $21.91weekly wages from Century 21 ($1,139.30 divided by 52 weeks) is $914.47 multiplied by 2/3 is $610.08.

The Arbitrator finds that Petitioner is entitled to TPD (temporary partial disability) for 48 4/7 weeks from January 3, 2011 through December 8, 2011 to be paid at the rate of $610.08/week. This would total $29,632.19. The parties have stipulated that the Respondent has paid a total of $47,483.06 in TPD benefits. (Arb.Exh. 1) The Arbitrator further finds that Respondent has over paid temporary partial disability by $17,850.86 and awards a credit in this amount against permanent partial disability.

2. With regard to the issue of the nature and extent of the Petitioner's injuries, the Arbitrator finds that the Petitioner has sustained a 27.5% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act. In support of this finding, the Arbitrator relies on both the Petitioner's testimony and the medical evidence that show Petitioner sustained injuries to his neck/back resulting in his need for a cervical fusion at C5, C6, and C7 with hardware. After undergoing postoperative physical therapy, Petitioner did not have any medical treatment to his cervical spine for more than three and one half years before the date of hearing. Further, Dr. Espinoza has

not made any further treatment recommendations and the Arbitrator finds that Petitioner does not require any further medical care for his cervical spine. The medical records further document that Petitioner is currently able to perform a very heavy physical demand level job and does not have any restrictions limiting his ability in the full performance of his job as an electrician.

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

Marvin Douglas,

Petitioner,

vs. NO: 13 WC 41999

16IWCC0446

Pepsi Bottling Group,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent partial disability, objections on record, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 21, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

16IWCC0446

The party commencing 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: JUN 3 0 2016
TJT:yl
o 5/9/16
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT

I respectfully dissent from the majority decision. Because the Petitioner proved all the elements of his case by a preponderance of the evidence, I would reverse the Arbitrator's decision and find that Petitioner sustained accidental injuries arising out of and in the course of his employment while working on November 11, 2013. I would also find that Petitioner's current condition of ill-being is causally related to his work incident. Accordingly, I would award Petitioner temporary total disability benefits from November 12, 2013 through February 3, 2014, reasonable and necessary medical expenses, and a permanent partial disability award of 25% for the loss of use of Petitioner's left leg.

The Petitioner testified that he sustained an injury upon jumping out of his work truck to the ground and felt a pain in his knee. He testified that this occurred during his second to last stop of his shift. Even though he was hurt, he finished out his shift and returned his work truck to Respondent's lot. The Petitioner went to the emergency room that evening for treatment, and he reported his work injury to his supervisor the next day.

The Petitioner's account of his accident is consistent with all of his medical providers, from his emergency room visit to his Section 12 examination. The Petitioner was diagnosed by his first treating physician, Dr. Joseph Monaco, with an acute rupture of the infrapatellar tendon. Dr. Monaco wrote of Petitioner's injury:

> I advised the patient this mechanism of injury is typical, almost 'textbook' for acute rupture of the patellar tendon. This is an injury that usually happens in a number of males in their 30s, with a deceleration-type injury like [sic] as described by [Petitioner] of jumping off the back of the truck, landing with the knees slightly flexed.

Subsequently, the Petitioner had a successful surgery performed on his left knee by Dr. Brian Weber.

On May 12, 2014 the Petitioner underwent a Section 12 examination by Dr. Brian Cole at Respondent's behest. Importantly, Dr. Cole opined that Petitioner's injury was causally related to his work accident:

> His need for treatment and prior diagnosis has been related to the injury date in question, given his report of the injury. I would add that it is rare for someone to be able to work in the fashion he did after an acute patellar tendon rupture, but [Petitioner] does describe a level of impairment and adjustment of his mechanics for the rest of the work day that seems to be consistent with the fact he incurred some level of injury. Assuming that there is no intervening incident between his end of work day and presentation to the emergency room...that night, then his impairment was related to the injury date in question and he incurred a work-related patellar tendon rupture of the left knee and had an appropriate repair.

There was no evidence presented to suggest that there was an intervening cause of Petitioner's injury or that an "intervening incident" took place. The fact that Respondent's witness, a fellow co-worker of Petitioner's, did not notice that Petitioner had changed the way he ambled in Respondent's parking lot post-injury is not enough to convince me that Petitioner did not sustain a work-related accident. All of the other evidence presented points towards Petitioner being injured on the job.

A claimant has the burden of proving all of the elements of his case in order to recover benefits under the Workers' Compensation Act. This burden of proof must be met by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 685 (Ill. App. Ct. 1st Dist. 1994). Given the medical evidence and Petitioner's testimony in this case, he has plainly met his burden of proof.

Furthermore, given that I would award Petitioner permanent partial disability benefits of 25% for the loss of use of Petitioner's left leg, I would note the following relevant §8.1b factors: There was no American Medical Association rating proffered as evidence, and there was no evidence that Petitioner would sustain a loss of income. The Petitioner was only thirty-three when he sustained his accident; given his age, the Petitioner could potentially live with the effects of his injury for many years. He also testified to some lingering effects from his injury such as a weaker left leg, instability issues, and right knee pain due to overcompensating for the left knee.

For the aforementioned reasons, I would reverse the Arbitrator's decision and find that Petitioner proved that he sustained an accident in the course of his employment when he was injured while working on November 11, 2013. I would also find that Petitioner's current condition of ill-being is causally related to his work incident. Consequently, I would award Petitioner workers' compensation benefits including temporary total disability, medical expenses incurred, and a permanent partial disability award of 25% for the loss of use of Petitioner's left leg.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOUGLAS, MARVIN
Employee/Petitioner

Case# **13WC041999**

PEPSI BOTTLING GROUP
Employer/Respondent

16IWCC0446

On 5/21/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1315 DWORKIN AND MACIARIELLO
ANTHONY L IVONE
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
MICHAEL CHALCRAFT
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

16IWCC0446

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

Marvin Douglas
Employee/Petitioner

v.

Pepsi Bottling Group
Employer/Respondent

Case # 13 WC 41999

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **February 27, 2015 and March 25, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] 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. [ ] Is Respondent due any credit?
O. [x] Other **Is Petitioner entitled to any prospective medical care?**

FINDINGS

On **November 11, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

In the year preceding the injury, Petitioner earned $**61,464.00**; the average weekly wage was $**1,182.00**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **0** dependent children.

ORDER

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

The Petitioner failed to prove a compensable accident therefore Petitioner's request for attorney's fees and penalties 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.

Richard L. Simpson
Signature of Arbitrator

May 21, 2015
Date

MAY 21 2015

16 IWCC0446

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marvin Douglas,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 41999**
	)	
Pepsi Bottling Group,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on November 11, 2013, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident that is the subject matter of this Petition for Adjudication within the time limits stated in the Act. They further agree that in the year preceding the alleged injury the Petitioner earned $61,464.00 and his average weekly wage, calculated pursuant to Section 10 of the Act, was $1,182.00.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of employment on November 11, 2013; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Is the Respondent liable for the unpaid medical bills from Advocate South Suburban Hospital, Dr. Joseph Monaco and Integrity Orthopedics; (4) Is the Petitioner entitled to TTD from November 12, 2013 through February 3, 2014; (5) What is the nature and extent of the injury; (6) Is the Petitioner entitled to penalties and attorney's fees; and (7) Is the Petitioner entitled to prospective care.

STATEMENT OF FACTS

The Petitioner is employed by the Respondent as bay truck delivery driver. He drives a truck that has seven bay doors on each side of the truck. The truck is loaded with 2 liter bottles and 12 ounce cans of Pepsi products including Gatorade and Starbucks coffee. The Petitioner is responsible for unloading product at delivery stops and moving it by dolly into the customers businesses. He also removes outdated product from the businesses and brings them back on his truck to the plant. Petitioner usually began work at 6:00 a.m. and finished when he returned to the plant after making his last delivery. There were times when his shift was eleven or twelve hours long. The time depended on the number of stops he had to make and the traffic. According to the Petitioner, at the end of the day he would return to the plant, park the truck, open the bay doors, punch out and go home.

On November 11, 2013, the Petitioner believes he started work at 6:00 am as usual. He stated that he had sixteen deliveries to make on that day. When he started the day he was in "stable, healthy condition." Near the end of his shift at what he believes was his second to the last stop, a "Mexican grocery store" named El Ranchito, the Petitioner testified that he injured his knee. The store is located at 127th and Western Avenue, which is a busy street with "lots of traffic." Petitioner is not allowed to park in the customer's parking to make the deliveries; he is required to park on the street about 300 yards from the store entrance where he makes the delivery.

Petitioner stated that he jumped out of the truck, threw his list and product down to the ground. He then he retrieved two liter bottles of product he crouched down to one knee with the cases of two liters which fell to the ground and scattered. He grabbed them all up so that they would not be stolen. He then went around the truck to get his dolly from the back, he got into the bay on the passenger side of the truck and when he jumped out onto the curb, about five feet down he felt a pop in his left knee. He testified that the pain felt like biting into an apple on a bad tooth and you move the food to the other side of your mouth. He described it as a one time, short, sharp pain. Petitioner described the pain as tolerable, but not excruciating after the first five seconds of the initial exquisite pain.

Petitioner testified he had to utilize the handcart like a crutch, leaning on it and he had to limp as he walked. In this way he was able to make the delivery to the grocery store and the stop which was after the grocery store. Petitioner testified that he then traveled to his last stop for his deliveries, a Walgreens, and completed the delivery before returning back to the Munster, Indiana distribution center. Petitioner testified that for the remainder of the day after he fell, he could not bend his knee and had to walk, climb into the truck and get out of the truck "stiff legged."

Petitioner testified that there was traffic, and when he arrived back at the distribution center, he punched out and went home. Petitioner testified there was no checker on site at the time he turned in his truck. He had no product remaining on his truck so he opened up the back of his truck, clocked out, and left. Petitioner testified he spoke to no one upon returning back to the Distribution Center.

On cross examination, Petitioner testified he was limping, and using the handcart for support. He had to adjust his deliveries, because of the injury to his knee, by making multiple trips with lighter weight. He confirmed that someone signed for the products he delivered at each location. Petitioner stated he had scratches on his hand as a result of the fall. Petitioner described having to compensate for his injury that night, and that he had difficulty ambulating. When asked by Respondent's attorney to demonstrate how he was walking, Petitioner was unable to recall what he did to alter his gait and could not demonstrate how he was moving.

Petitioner testified he has regular knee pains as part of his job. Petitioner testified that, despite the knee pain, he was able to move, and compensated by taking lighter loads on the handcart and making more trips. Petitioner did not call the Distribution Center to report the injury to his left knee. Petitioner testified that the trucks do not have radios, but he did have a cell phone on him.

Petitioner testified that although he was having substantial pain at home his wife did not want him to go to the hospital. Petitioner testified that eventually the pain was so great that he went to the ER at Advocate South Suburban. The medical records indicate that Petitioner reported that his knee buckled when he jumped off of a truck that day and that he has had difficulty walking since the incident. X-rays were taken and they showed no fractures or dislocations. They determined that he had Prepatellar soft tissue swelling suggestive of prepatellar bursitis. (PX. 1, p. 12, 13, 30). A second medical note in the same report indicates that he reported "he felt his left knee pop and then a tearing feeling around 4 pm today while loading a truck." (PX 1, p. 14, 20, 47) Petitioner was given a knee immobilizer and crutches according to the records. (PX 1, p. 16)

Petitioner testified that on November 12, 2013, he informed his supervisor, Jason Whitt, that he hurt himself the previous day.

Petitioner testified that on November 12, 2013, he saw Dr. Joseph Monaco to evaluate his left knee. Petitioner reported to Dr. Monaco that on November 11, 2013 he jumped off the back of his truck, about 2 to 3 feet off the ground and when he landed his knee buckled. He tried to walk and his knee buckled again. He stated that the knee became more painful throughout the day as he tried to finish his route. (PX 2) Dr. Monaco diagnosed Petitioner with an acute rupture of the infrapatellar tendon. Dr. Monaco referred Petitioner to Dr. Daniel Weber for surgery. (PX 2). Dr. Monaco took Petitioner off of work. (PX 2).

On November 15, 2013, Petitioner saw Dr. Daniel Weber. Petitioner reported to Dr. Weber that he was throwing some cases down at work and jumped down and felt a pop in his knee. Petitioner was diagnosed with a ruptured patellar tendon. (PX. 3).

On November 21, 2013, Dr. Weber performed a left patellar tendon repair.

Petitioner remained off work pursuant to Dr. Weber. (PX 3). Petitioner remained off work throughout the duration of his physical therapy. Dr. Weber released Petitioner back to work on February 3, 2014.

On May 12, 2014, Petitioner attended a medical evaluation with Dr. Brian Cole, at the request of the Respondent, pursuant to Section 12 of the Act. The Petitioner gave a history of the accident to Dr. Cole reporting that he was close to the end of the day when he jumped down out of the side entrance of the truck, approximately a 36 inch leap. He stated that his left leg buckled when he landed and he felt an odd sensation. He reported that he needed to work "stiff legged" for the rest of the shift and had complaints of tightness in his quads, but reported that he was able to still swing his left leg to move the dolly, lift, and leap stiff-legged out of the truck. (PX 4, p.1/4) Petitioner told Dr. Cole that he worked three more hours, using a stiff knee adjustment and that he was not able to squat, kneel, stoop or climb as he normally would. (PX 4, p. 1/4, 2/4)

Dr. Cole opined that not only was the treatment to date reasonable and necessary, but that Petitioner would benefit from an additional 8 weeks of rehabilitation as he had not yet reached MMI. It was Dr. Cole's opinion that the Petitioner would reach MMI at the end of those 8 weeks after further therapy. Dr. Cole indicated that Petitioner's need for treatment and prior diagnosis has been related to the injury date in question, based upon the Petitioner's report of injury. However, Dr. Cole noted that it is rare for someone to be able to work in the fashion the

Petitioner did after an acute patellar tendon rupture. He stated that Petitioner described a level of impairment and adjustment of his mechanics for the rest of the workday that seems to be consistent with the fact that he incurred some level of injury. Dr. Cole was not able to explain how Petitioner was able to manipulate a dolly or get down out of the truck with a ruptured patellar tendon. Assuming there was no intervening incident between the end of Petitioner's work day and his presentation to the emergency room at 8:00.p.m. Dr. Cole opined that Petitioner's injury was causally related to his work accident of November 11, 2013. (PX 4, p. 3/4).

Respondent's witness was unavailable to testify at the close of Petitioner's proofs on February 27, 2015, and the case was recessed and continued to March 25, 2015, for Respondent's case in chief.

On March 25, 2015, Respondent called David Hyska to testify. Mr. Hyska testified that on November 11, 2013, he was working as a checker at the Munster, Indiana Distribution Plant. He testified that he has worked for Pepsi for about 40 years. He worked as a night foreman in a warehouse for 5 to 6 years, was a delivery truck driver for 17 years, a warehouse manager for 18 years, and has been a checker since March 30, 2013.

Mr. Hyska described the process of checking delivery trucks in and out. At the beginning of a delivery driver's shift, Mr. Hyska would go through and scan the trucks to ensure the door seals were not broken, and the product was accounted for. At the end of a shift, when a driver returns the truck, the checker confirms the amount of product that is returned. Expired/damaged product is discarded by the driver, while the checker completes the inspection. Mr. Hyska was the only checker on duty on November 11, 2013. All trucks must return and check-in with the checker. One of the reasons for this, is so the driver can then proceed to the cashier, and turn over any cash they have on-hand from their deliveries. However, they must be checked-in first. This process is accounted for by the use of a handheld terminal, which documents all products assigned to that driver. The handheld terminal stays with the driver throughout their deliveries. You cannot leave at the end of your shift, without checking your truck back in and accounting for your product.

Mr. Hyska testified that he remembered seeing Petitioner at the beginning of his shift, around 6:30 A.M. Petitioner was walking fine. At the end of the shift on November 11, 2013, Mr. Hyska testified that he remembered seeing Petitioner and checking-in his truck. Mr. Hyska testified that Petitioner was walking normally, and nothing appeared to be wrong with him. According to Mr. Hyska the Petitioner did not show signs of limping, using the handcart as a crutch, being stiff-legged, lock-legged or swinging his leg as he walked. Petitioner did not report or complain of any pain or injury to Mr. Hyska. Mr. Hyska admitted that he was not the person to whom employees would report injuries that they sustained on the job.

Mr. Hyska also testified that he remembered seeing the Petitioner on the morning of November 12, 2013 and noticed that he was wearing a knee brace. He testified that he asked the Petitioner what happened and the Petitioner kept walking and did not answer him.

Mr. Hyska testified that all drivers are assigned a cell phone to communicate with the company if a driver needs assistance. Mr. Hyska was asked by Jason Whitt, two days later, whether Petitioner had reported any injury, or showed signs of a limp when Mr. Hyska interacted

with him at the close of the day on November 11, 2013. Mr. Hyska said no to both. According to Mr. Hyska Jason Whitt no longer works for the company.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

"Preponderance of the evidence is evidence which is of greater weight or more convincing than the evidence offered in opposition to it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Central Rug & Carpet v. Industrial Commission*, 838 N.E.2d 39 (1st Dist. 2005).

An employer's liability for benefits cannot be based on guess, speculation or conjecture. *Illinois Bell Telephone* v. *Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 207 (1994).

Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission*, 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission*, 52 Ill. 2d 490 (1972).

The testimony of the employee, if not impeached or rebutted, is sufficient to support an award. *Phoell Manufacturing Co. v. Industrial Commission,* 54 Ill. 2d 119, 295 N.E. 2d 469 (1973) *Sahara Coal Co. v. Industrial Commission,* 66 Ill.2d 353, 362 N.E.2d 343 (1977)

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent, the Arbitrator makes the following conclusions of law:

After reviewing the evidence in its' entirety, weighing the credibility of the witnesses and their testimony, examining the medical records provided by the Petitioner and the process and procedures Respondent has in place for the delivery drivers at the end of their shift, the Arbitrator concludes the Petitioner has failed to prove by a preponderance of the evidence, that

he sustained accidental injuries arising out of and occurring in the course of his employment with the Respondent.

The Petitioner testified that after the incident he had difficulty walking. He was limping, walking "stiff legged" and using the dolly as a crutch. He stated that he took smaller loads of the product into the stores which necessitated more trips. He also maintained that he repeatedly climbed into and out of the truck and the bays which held the product in order to make the delivery where the injury is supposed to have occurred as well as the next one. Dr. Cole wrote in his report that it is rare for someone to be able to work in the fashion Petitioner did after an acute patellar tendon rupture. Dr. Cole could not explain how Petitioner was able to manipulate a dolly, nor get down out of a truck with a ruptured patellar tendon.

Petitioner testified further that no one was at the distribution center when he returned at the end of his shift, so he did not see anyone, except maybe one other driver. He testified that his truck was empty so he opened up all the bays and left. Mr. Hyska testified that he was the only checker working on Monday, November 11 and he was present at the facility when the Petitioner arrived at the end of his shift. Mr. Hyska recalled observing Petitioner that day, and specifically noted no indication Petitioner was in pain, or injured when he returned from making his deliveries. Petitioner was neither stiff-legged, nor limping. Mr. Hyska checked the Petitioner in and walked with him to the cashier, giving Mr. Hyska ample opportunity to observe the Petitioner as he walked around the truck and the plant. Mr. Hyska remembered Petitioner not being injured on November 11 because, the next day, November 12, 2013, Petitioner returned to work with a leg brace, and Mr. Hyska asked Petitioner what happened. Additionally, Mr. Hyska was asked on November 12 by Jason Whitt, if Petitioner had been limping on November 11. Mr. Hyska remembered seeing Petitioner at the end of his delivery, with no limp or impaired gait whatsoever and advised Mr. Whitt of that fact.

Dr. Cole is the only medical opinion entered into evidence that addressed the issue of work-relatedness. Dr. Cole based his opinion that this was a work-related patellar tendon rupture of the left knee, on the accuracy of what Petitioner told him and the assumption there was no intervening incident between the end of workday and the presentation to the emergency room. Dr. Cole, taking Petitioner's story at face value, qualified his findings by adding that it is rare for someone to be able to work in the fashion Petitioner did after an acute patellar tendon rupture. He was unable to explain how Petitioner could manipulate a dolly, or get down out of the truck with a ruptured patellar tendon.

Essentially, Dr. Cole found that, given the significant adjustment, whereby Petitioner was walking stiff-legged and swinging his leg for approximately 3 hours while manipulating a dolly, lifting and leap in and out of his truck, then under those circumstances it was conceivable Petitioner sustained an injury consistent with his history. However, Mr. Hyska did not observe this behavior when he encountered the Petitioner at the end of the day. Additionally, when asked on cross-examination to demonstrate how he was walking at the time and the accommodations that he made due to the injury Petitioner was unable to do so.

Petitioner's trial testimony has numerous inconsistencies with the other evidence and calls into question the veracity of it. Perhaps most instructive from Mr. Hyska's testimony, was

the process and procedure a driver must go through when returning a truck at the end of their deliveries. Petitioner testified he dropped off his truck, opened the 14 bays, clocked out, and left. Petitioner testified that the only person he saw was another driver. Additionally, according to Petitioner, he had no product left in the truck, so there was no reason to check it in. Petitioner testified that he spoke to no one.

This testimony is inconsistent with the dedicated procedures described by Mr. Hyska. Every driver is required to account for the product on their truck, through the use of the handheld terminal the driver keeps with them. If you have no product, then you have to report that to the checker. If you have product that is damaged our expired, then the driver disposes of that product, while the checker finishes the inspection. After being checked-in, the driver reports to the cashier because drivers have cash from the sales that day, which must be turned in to the cashier at the end of the shift. Petitioner stated that all of his bays were empty, and that is why he did not check-in with anyone. His product was sold, destroyed, or discarded, so he would still have to check-in with the checker and would have to report to the cashier to turn in the money he collected from his deliveries. Clearly a truck driver does not simply drop off their truck and walk away.

Also troubling is the fact that the Petitioner testified that he had the company issued cell phone with him, yet he failed to call and report his injury so that someone could come and relieve him of the remainder of his work and take him for medical treatment right away get help with his remaining deliveries after the injury is alleged to have taken place. Petitioner's recitation of the events is inconsistent with witness testimony, medical opinions and the dedicated procedures of the employer.

In light of all of the evidence, the Arbitrator finds that the Petitioner failed to meet his burden by a preponderance of the evidence, that an injury took place that arose out of, and occurred in the course of his employment during his shift on November 11, 2013.

Is the Petitioner's current condition of ill-being causally connected to this injury or exposure? Is the Respondent liable for the unpaid medical bills from Advocate South Suburban Hospital, Dr. Joseph Monaco and Integrity Orthopedics? Is the Petitioner entitled to TTD from November 12, 2013 through February 3, 2014? What is the nature and extent of the injury? Is the Petitioner entitled to penalties and attorney's fees? Is the Petitioner entitled to prospective care?

The Arbitrator specifically incorporates and restates her findings regarding whether Petitioner sustained accidental injuries that arose out of and in the course of his employment, above, into this section regarding the remaining issues at the hearing. The Petitioner has failed to prove a compensable accident pursuant to the Act. The above listed issues are moot.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

The Petitioner failed to prove a compensable accident therefore Petitioner's request for attorney's fees and penalties is denied.

Deborah L. Simpson
Signature of Arbitrator

May 21, 2015
Date

STATE OF ILLINOIS)
) SS
COUNTY OF MC LEAN)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Zimmer,

Petitioner,

No. 14 WC 39633

Technical Metals, Inc.,

Respondent.

ORDER

Petition for Review having been filed by Petitioner's attorney herein this matter came before Commissioner Gore on May 3, 2016 and at Oral arguments on May 5, 2016. The Commission having jurisdiction over the persons and subject matter and after being advised in the premise finds:

1. The Arbitrator filed a Decision on this matter on August 28, 2015.

2. Respondent filed a timely Petition for Review on September 24, 2015.

3. Transcript was filed December 29, 2015.

4. On January 7, 2016 Petitioner filed its' own Petition for Review.

The matter was taken under consideration by the Commission on May 5, 2016.

The Commission finds that Petitioner failed to perfect his Petition for Review, filing it well past the statutory deadline. Accordingly, the Commission hereby dismisses Petitioner's Petition for Review

THEREFORE IT IS ORDERED BY THE COMMISSION that Petitioner's Petition for Review is hereby dismissed.

DATED: JUN 30 2016
DLG/wde
5/5/16
45

David L. Gore

Mario Basurto

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF MC LEAN)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT ZIMMER,

Petitioner,

vs.

NO: 14 WC 39633

16IWCC0447

TECHNICAL METALS, 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, wage rate, medical expenses, temporary total disability 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 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 FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner began working for Respondent in September 2011 as a Truck Driver. He delivered parts to different companies. 99 percent of the time he was not asked to load or unload the parts. He usually worked 3 days per week and earned $12/hour. He did not work overtime.

2. On October 23, 2014 Petitioner was driving parts back from Indiana in a cube van. He was 5 miles away from Respondent's place of business when he stopped at a stop sign. When he took off again the load he was carrying shifted and fell out of the back of the van, broke the back door and fell onto the road.

3. Petitioner got out and began picking up the pieces that were scattered. Each piece weighed 15-18 pounds. He was assisted by 4 or 5 other people. Petitioner and 3 helpers lifted a 300 pound metal tub that was holding the parts 3.5 feet off the ground, and placed it back in the van. Petitioner and 1 helper also lifted a 100 pound tub back into the van. This whole ordeal took 15-20 minutes.

4. After lifting the second tub Petitioner experienced bilateral shoulder pain. He treated at St. James Hospital and was referred to OSF Occupational Health. He was unable to do much of anything with his left shoulder, but, despite his pain, he was able to do most everything they asked of him with his right shoulder.

5. On November 24, 2014 Petitioner treated with Dr. Novotny due to his ongoing bilateral shoulder pain.

6. Petitioner returned to light duty work for Respondent in late November 2014. He worked 4 hours per week. He worked light duty until January 2015, when Respondent's doctor released him, and Respondent did not have any work available for him. Petitioner has not seen any treating physicians since November 2014. He stated that he cannot afford to go.

7. Petitioner stated on Direct examination that he has never injured either shoulder before, but has undergone surgery on his left bicep. However, on Cross examination he admitted to previous left shoulder treatment, including a SLAP repair. Further, medical records in the record clearly indicate that Petitioner also received previous right shoulder treatment for a type 2 tear of the superior labrum, rotator cuff tendinosis and moderate AC arthrosis. Petitioner also failed to mention any right shoulder issues on his Employee Injury Report completed after the accident.

8. Although the accident occurred on October 23, 2014, medical records are silent on any cervical spine issues until November 25, 2014, when Dr. Novotny recommended a cervical MRI. However, it must be noted that Dr. Novotny recommended the same on June 7, 2011, over 3 years prior to the accident in question.

9. Petitioner had significant left shoulder treatment prior to the accident. He continuously treated with Dr. Novotny from September 18, 2009 through June 7, 2011, had permanent lifting restrictions assigned to him, and indicated that his condition in 2011 was no better than what it was prior to his SLAP repair.

10. An October 2009 left shoulder MRI revealed tendinopathy with no evidence of a full tear. The operative report of the surgery performed the following month revealed fraying on the bursal surface of the rotator cuff. A November 2014 left shoulder MRI revealed a partial or complete tear of the supraspinatus tendon, which had not previously been contemplated.

11. There is no evidence in the record of any medical expert finding causal connection between the accident in question and Petitioner's current left shoulder condition.

12. Dr. Monaco performed an Independent Medical Examination (IME) on January 2, 2015 and opined that Petitioner suffered a temporary aggravation of a pre-existing left shoulder condition. He also opined that Petitioner had reached Maximum Medical Improvement (MMI).

The Commission affirms the Arbitrator's finding of no causal connection with respect to Petitioner's alleged cervical spine and right shoulder conditions.

The Commission also affirms the Arbitrator's rulings on wage rate and temporary total disability.

However, the Commission modifies the Arbitrator's finding of causal connection to Petitioner's current left shoulder condition of ill-being. There is no medical opinion in the record finding such causation, and the only medical opinion regarding Petitioner's left shoulder was offered by Dr. Monaco, who opined that causal connection terminated as of January 2, 2015. Moreover, it is difficult to surmise the true nature of Petitioner's left shoulder condition just prior to the accident in question, as Petitioner provided inconsistent medical histories. With no credible basis to find otherwise, the Commission relies on the opinion of Dr. Monaco, and terminates causal connection to Petitioner's left shoulder condition on January 2, 2015.

The Commission also modifies the Arbitrator's ruling with respect to medical expenses awarded. The Commission modifies the award to include all related medical expenses stemming from Emergency Room treatment at OSF St. James Hospital.

IT IS THEREFORE ORDERED BY THE COMMISSION that causal connection related to Petitioner's left shoulder condition is terminated as of January 2, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner for medical expenses related to Emergency Room treatment 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

16IWCC0447

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 $1,100.00. 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.

JUN 3 0 2016

DATED:
O: 5/5/16
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

ZIMMER, ROBERT
Employee/Petitioner

Case# **14WC039633**

TECHNICAL METALS INC
Employer/Respondent

16IWCC0447

On 8/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.20% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2028 RIDGE & DOWNES LLC
JOHN E MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL VICTOR
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

16IWCC0447

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)

ROBERT ZIMMER,
Employee/Petitioner

Case # **14 WC 39633**

v.

Consolidated cases:

TECHNICAL METALS, INC.,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS MCCARTHY**, Arbitrator of the Commission, in the city of **BLOOMINGTON**, on **June 30, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to Respondent?

F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?

G. ☒ What were Petitioner's earnings?

H. ☐ What was Petitioner's age at the time of the accident?

I. ☐ What was Petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. ☒ Is Petitioner entitled to any prospective medical care?

L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other

FINDINGS

On the date of accident, **October 23 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being is partially causally related to the accident.

In the year preceding the injury, Petitioner earned $3859.96; the average weekly wage was $214.44.

On the date of accident, Petitioner was 54 years of age, ***single*** with dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

ORDER

Causation

The Arbitrator finds the Petitioner's current condition of ill being with respect to his left shoulder causally related to his accident; He further finds the Petitioner's conditions with respect to the right shoulder and cervical spine no causally related.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $ **214.44** /week for **2 6/7** weeks, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $**426.63** , as provided in Section 8(a) of the Act under the Medical fee Schedule.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of McLean County Orthopedics for date of service 11/25/14 for $309.17 and St. James Occupational for date of service 10/28/14 for $79.09 and date of service 11/13/14 for $38.37, as provided in Sections 8(a) and 8.2 of the Act.

Respondent is not liable for the prospective medical treatment involving the cervical spine recommended by Dr. Novotny.

In no instance shall this award be a bar to a subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Dylan McCarthy
Signature of Arbitrator

August 19, 2015
Date

ICArbDec19(b)

AUG 28 2015

16IWCC0447

STATE OF ILLINOIS)
) ss.
COUNTY OF McLEAN)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Zimmer

Petitioner,

v.

Technical Metals, Inc.

Respondent.

Court No. 14 WC 39633

FACTS

The Petitioner testified that he was a truck driver who began working for the Respondent in December 2001. He initially indicated that he worked 3 days per week but later admitted this was untrue. The Petitioner indicated that he was driving a load from Indiana when he stopped at a stop sign and the load shifted. The back door swung open and parts spilled out the back. The parts that fell out were 33 pieces, 22 in one tub and 11 in another. The parts weighted between 15 and 18 pounds. The tub with 22 pieces did not fall out but the pieces inside did. The Petitioner and 4 to 5 bystanders picked up pieces and placed them in the tub in the truck. The tub with 11 pieces fell out entirely and the pieces were placed back in the tub and the Petitioner and the bystanders lifted the tub back in the truck. The Petitioner did not know how much the tub weighed but speculated it might be 100 pounds. The Petitioner testified the tub was lifted about 3 and one half feet. The entire operation took approximately 15 to 20 minutes.

The Petitioner testified he was in pain in his left shoulder following the lifting activities and his right shoulder hurt "for awhile". He testified that he saw Dr. Novotny and complained of right shoulder pain on movement, with overhead reaching and behind his back. He could hardly lift his right arm or reach with his left shoulder. He returned to work light duty in November working four hours a week the first two weeks and 8 hours until January following an IME doctor release.

The Petitioner testified that Dr. Novotny placed him on light duty. The Petitioner testified that he never injured his right or left shoulder previous to 10/23/14. He testified he only injured his left bicep previous to that date.

The Petitioner testified that he agreed to work 3 days per week for the Respondent and sometimes worked 5 days a week. He later admitted that there was no actual agreement on 3 days per week work but that this was his preference.

On cross-examination the Petitioner admitted that he worked infrequently and sometimes went months without working. He denied right or left shoulder injuries prior to the date of accident despite being confronted with prior medical records and his prior Workers' Compensation contracts indicating both right and left shoulder injuries and treatment. The Petitioner indicated he told the Emergency room of both his left and right shoulder pain despite the fact that the records of the Emergency room indicated only left shoulder pain.

F. CAUSAL CONNECTION

The Arbitrator finds that the Petitioner was not a credible witness. The Petitioner initially denied any prior injury to his right or left shoulder. It became clear during the course of cross examination that the Petitioner was untruthful in this regard. The Petitioner had two prior workers' compensation claims involving his left shoulder wherein the Petitioner had a SLAP repair surgery on the left shoulder. Rx. 5. settlement contracts 09 WC 1966 and 11 WC 29791 and Rx. 7 medical records of Dr. Novotny. The Petitioner clearly had pre-existing right shoulder injury as a result of the 11 WC 29791 injury. This is listed as left and right arm on the settlement contracts. Rx. 5 and the medical records of Dr. Novotny document the treatment for the right shoulder as well. Rx. 7.

the treatment records of Dr. Novotny clearly indicate that the Petitioner had a previous right shoulder impingement and difficulties for the prior workers' compensation injury 11 WC 29791. On January 20, 2011, Dr. Novotny noted an MRI of the right shoulder revealed a type 2 tear of the superior labrum, rotator cuff tendinosis and moderate AC arthrosis. On 2/17/11, Dr. Novotny recommended surgical repair for the right shoulder but the Petitioner wanted to wait until the next year. Rx 7.

The Petitioner testified that he injured his right shoulder as part of the current alleged work accident. The medical records and accident reports suggest otherwise. The emergency room records fail to indicate any suggestion of right shoulder pain and reflect only left shoulder pain. Rx. 1. In addition, the Petitioner was treated by the occupational health doctor on October 24, 2011 and October 28, 2011 without any mention whatsoever of right shoulder pain. The Petitioner only mentioned first his right shoulder pain in any medical record on November 25, 2014 when he suggested he had right shoulder pain all along with the occupational doctor. Px. 1. The Petitioner reported that he had immediate right shoulder pain; however, the accident report suggests otherwise. The accident report filled out and signed by the Petitioner on the day of the accident suggests only left shoulder pain. Rx. 4.

In light of the above, the Arbitrator finds that the Petitioner's right shoulder condition is not causally related to his accident.

With respect to the cervical spine, the Arbitrator notes no complaints of cervical spine symptoms or neurological symptoms down either arm appear in the medical until Dr. Novotony's examination of November 25, 2014. He indicates that the Petitioner should undergo an MRI of his cervical spine and cervical workup. It should be noted that the recommendation for a cervical evaluation was made on June 7, 2011 by Dr. Novotny as well. The Petitioner indicated at that time that "he has from the start had a long term history of numbness and tingling radiation into both hands with limited cervical spine motion." Rx. 7 The Petitioner also did not testify that he had any cervical symptoms following his accident. It appears that Dr. Novotny is only recommending the cervical treatment because of a positive Spurling's test during his visit of November 25. Based upon the above, the Arbitrator finds the cervical spine condition not causally related to the accident. The request by Dr. Novotny for further cervical spine treatment is therefore denied.

As is noted above, the Petitioner had extensive treatment to his left shoulder prior to his accident. He underwent numerous MRI's and three surgeries. He treated continuously with Dr. Novotny from September 18, 2009 through June 7, 2011. On that date, according to Dr. Novotny's records, the Petitioner said his left shoulder was no better than before his surgeries. Permanent restrictions with respect to the left shoulder were recommended by Dr. Mash limiting lifting to 50 pounds to only the waist level on April 20, 2011. Dr. Novotny reviewed said report during his final visit with the Petitioner on June 7, 2011 and said that it was a reasonable review.

On the other hand, the Petitioner worked for the Respondent on a part time basis from 2011 through his accident and testified that his work did not require lifting with the left arm. His accident did require him to help lift a heavy tub full of parts in excess of the above referenced restrictions. He felt immediate pain in the left shoulder. The emergency room records showed decreased range of motion and pain. He was given work restrictions. An MRI done on November 19, 2011 revealed a partial or complete tear of the supraspinatus tendon. Both Dr. Novotny and Dr. Monaco reviewed the scan and opined that it showed a possible tear of the rotator cuff. While the operative reports and MRI's done prior to the accident revealed various left shoulder conditions, none showed a complete tear of the supraspinatus. The MRI of October 16, 2009 showed tendinopathy with no evidence of a full tear. The operative report of November 23, 2009 showed only fraying on the bursal surface of the rotator cuff.

Based upon the above evidence, the Arbitrator finds the Petitioner sustained an aggravation of his pre-existing shoulder condition in his accident as alleged.

K. PROSPECTIVE MEDICAL

For the reasons outlined above, the Arbitrator denies the Petitioner's request for the cervical spine treatment recommended by Dr. Novotny as the condition is not causally related to his accident.

L. TEMPORARY TOTAL DISABILITY

The Petitioner was placed on work restrictions by the OSF emergency room physicians following his visit on the accident date. OSF occupational health continued those restrictions. On November 7, 2014, Respondent offered the Petitioner light duty through a letter, stating that he had to respond within five days. Petitioner said that he did return to light duty work sometime in late November. No evidence was presented as to the exact date. Based upon the above evidence, the Arbitrator finds the Petitioner entitled to TTD benefits from October 24, 2014 through November 12, 2014, a period of 2 6/7 weeks.

G. AVERAGE WEEKLY WAGE

The Petitioner initially alleged that he worked three days a week by agreement. However, there is no evidence to suggest that the Respondent agreed to three days per week. Instead, the Petitioner eventually indicated that three days a week was preferred and nobody really agreed to that. The average weekly wage statement provided by Respondent Rx. 6 suggests that the Petitioner did not work three days a week, and in fact, the Petitioner himself admitted that there were many months that he did not work at all per the wage statement. The wage statement reveals that the Petitioner earned a total of $3859.96 for the period between October 23, 2013 and October 23, 2014. It also shows that the Petitioner worked 18 weeks during that time. Rx. 6. The Petitioner did not present any evidence from which the Arbitrator could determine whether any of those weeks represented partial weeks worked. The Arbitrator notes that the Petitioner is a part time worker and calculates the average weekly wage by dividing the $3859.96 by 18 weeks for an AWW of $214.44 per week.

J. MEDICAL BILLS

The Arbitrator finds the Respondent liable for the medical bills submitted in Petitioner's Exhibits 4 through 6, subject to the Fee Schedule, incorporating by reference his decision on causation.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Wagner,

Petitioner,

vs.

NO: 15 WC 10538

16IWCC0448

The Salvation Army,

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, prospective medical, causal connection, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 20, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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: JUN 3 0 2016

MB/mam
o:6/9/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

WAGNER, CHRISTOPHER
Employee/Petitioner

Case# **15WC010538**

16IWCC0448

SALVATION ARMY
Employer/Respondent

On 10/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1189 WOLTER BEEMAN & LYNCH
FRANCIS J LYNCH
1001 S 6TH ST PO BOX 5276
SPRINGFIELD, IL 62705

0000 NYHAN BAMBRICK KINZIE & LOWRY
ADAM J COX
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

16IWCC0448

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHRISTOPHER WAGNER
Employee/Petitioner

Case # 15 WC 010538

v.

Consolidated cases: _____

SALVATION ARMY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Molly Dearing**, Arbitrator of the Commission, in the city of **Urbana**, on **August 12, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, 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 **$20,576.44**; the average weekly wage was **$395.70**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **4** children under 18.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$2,640.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,640.00**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

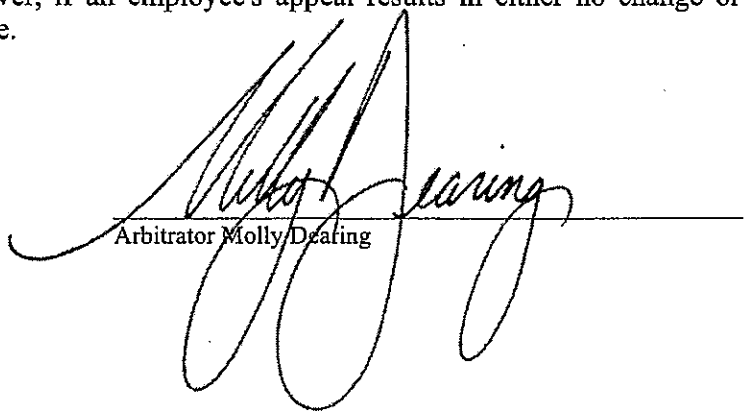
Respondent shall pay all reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay for all reasonable and necessary prospective medical treatment, including, but not limited to, physical therapy relative to Petitioner's low back 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.



Arbitrator Molly Daring

October 8, 2015
Date

OCT 20 2015

16IWCC0448

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHRISTOPHER WAGNER
Employee/Petitioner

v. Case No. 15 WC 10538

THE SALVATION ARMY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On his date of accident, Petitioner was thirty-four years of age (Arb. X 1) and employed by Respondent as a truck driver. He had been employed by Respondent for six months. In his capacity of a truck driver, he drove a truck, delivered products, and retrieved and returned items from and to Respondent's stores. Petitioner testified that his position as a truck driver involved bending and stopping. Prior to his position as a truck driver, Petitioner testified that he worked for Respondent an assistant dock foreman, which involved lifting and carrying.

Petitioner testified that on January 6, 2015, he and another employee traveled to Kankakee, Illinois to retrieve a load of items to return to Respondent's stores to sell as wholesale. He described the weather that day as windy with ice and snow. Petitioner testified that the truck hit an ice patch, tipped over, and eventually came to rest in a ditch. He notified Respondent. Petitioner testified that he does not recall what happened to his body while in the truck and he denied noticing anything about himself when he emerged from the truck because he was "out of it." Petitioner was unsure as to whether he was limping and he had no recollection of suffering specific pain thereafter. He testified that his supervisor and Captain Rutledge arrived at the scene, and insisted he present to the hospital for treatment.

On January 6, 2015, Petitioner presented to the Emergency Department at Memorial Medical Center with complaints of leg pain after a motor vehicle accident in which the truck he was driving rolled over. He denied loss of consciousness, head or neck pain. An x-ray of the left lower leg revealed no acute fractures. Petitioner was diagnosed with a contusion of the lower extremity and discharged home with instructions to follow up with his primary care physician. PX 1, RX 1. Petitioner testified that he was briefly examined by a physician after what he described as a lengthy wait. He testified that no x-rays were taken and no medical orders were given on that date.

Petitioner testified that after he was released from the hospital, he developed sharp pain in his low back while sitting down watching television on January 7, 2015. He returned to work on January 9, 2015. Petitioner testified that at that time, he was experiencing significant pain in his low back and difficulty walking. He notified his supervisor, and he stated that both his supervisor and Captain Rutledge had an opportunity to observe him ambulating and moving about the office. His supervisor advised him to sit down, and Captain Rutledge inspected his leg and recommended he seek treatment.

Petitioner presented to Express Care on January 9, 2015 and reported pain, swelling, and pressure in his lower extremity worsened by walking following a motor vehicle accident, and pain in the lower back and left arm that began "after the accident". Petitioner necessitated further evaluation and a possible ultrasound to rule out deep vein thrombosis, and he was transferred to the emergency department at Memorial Medical Center. PX 1, 2.

In the Emergency Department, Petitioner presented with complaints of swelling and pain in his left lower extremity, and intermittent back pain since a motor vehicle accident. He reported presenting to the emergency room at the time of the accident where he was "told [he] would be sore a while but work wants him rechecked." A left lower extremity venous Doppler revealed subcutaneous edema in the medial aspect of the lower leg in the area of clinical concern, but no deep vein thrombosis. Petitioner was diagnosed with a contusion of the lower extremity, discharged home with prescriptions of Toradol, Flexeril and Norco, and instructed to follow up with his primary care physician. PX 1. Petitioner testified that upon presenting to the emergency department on January 9, 2015, he was able to speak to medical personnel about the pain in his leg and back, and he underwent a physical examination. Thereafter, Respondent accommodated his restrictions and upon returning to work subsequent to January 9, 2015, Respondent placed him as an assistant foreman on the dock and he was provided assistance with lifting.

On January 14, 2015, Petitioner presented to Dr. Arun Abraham with complaints of left leg pain. He reported that his pain continues to shoot up and down his leg, and he occasionally experienced tingling in his leg. A physical examination of his left foot and ankle revealed ecchymosis along the medial aspect of the foot, tenderness along the medial aspect of the foot as well as the lateral aspect of the ankle, normal strength and range of motion, normal pedal and posterior tibial pulses, normal sensation, and no evidence of erythema, abrasions or bleeding. Dr. Abraham assessed him with an ankle sprain and contusion of the left foot. He did not prescribe any medications, but he instructed Petitioner to alternate Motrin with Tylenol every four hours, and to return to Dr. Omar Vargas as instructed by the emergency department. RX 3.

On January 15, 2015, Petitioner presented to Nurse Practitioner Leanne Novar at SIU Center for Family Medicine and complained of left ankle pain. He was diagnosed with a left ankle sprain, prescribed Cyclobenzaprine and Norco, and he was removed from work until January 29, 2015. PX 3, RX 4.

On January 29, 2015, Petitioner presented to Dr. Michael Owolabi at SIU Center for Family Medicine and complained of swelling and pain in his left ankle, as well as back pain "that has not improved much." Dr. Owolabi ordered an MRI of the left ankle and physical therapy. PX 3, RX 5.

An MRI of the left ankle of February 6, 2015 revealed diffuse nonspecific subcutaneous edema medial more than lateral and edema in the pre-Achilles fat pad suggesting Achilles peritendinitis. PX 3.

On February 9, 2015, Petitioner presented to Dr. Owolabi and complained of swelling and pain in his left leg that occasionally radiated up to his hip. He reported that he was unable to walk without a brace on his left ankle. Petitioner rated his left leg pain as a four on a ten-point scale. He also reported low back pain that "started yesterday" as he was "attempting to move a 30lb box when he hurt himself. Did not hear any sounds but just felt he might have aggravated his back when attempting to move the box." Dr. Owolabi instructed Petitioner to discontinue Norco, he

prescribed him Naproxen and Flexeril, and ordered him to undergo physical therapy. PX 3, RX 2. Petitioner testified that he attempted to lift a box at home that weighed approximately twenty-five pounds. He stated that doing so aggravated his back. Petitioner explained that prior to lifting the box, he experienced sharp low back pains, and thereafter, he experienced a dull ache in addition to the sharp pain.

Petitioner returned to Dr. Owolabi on March 6, 2015 and continued to complain of back pain and left ankle sprain since a motor vehicle accident on January 6, 2015. He reported an inability to work "because of difficulty with ambulation after the MVA." A physical examination showed no edema in the lower extremities or neurological deficits. Dr. Owolabi allowed Petitioner to return to work with restrictions of no lifting more than ten pounds and no climbing ladders, and instructed him to continue therapy. PX 3.

On March 26, 2015, Petitioner presented to Dr. Owolabi. He complained of leg pain while sitting as a four on a ten-point scale, swelling at nighttime, intermittent tingling in his left upper extremity and back pain, though he denied ankle swelling. "Ankle pain began after an MVA that he suffered on January 6th, 2015 and back pain began after lifting a box on 2/8/15." Dr. Owolabi instructed him to discontinue use of Cyclobenzaprine, to continue Naproxen, and he ordered Petitioner undergo physical therapy. PX 3, RX 6.

On April 2, 2015, Petitioner presented to Dr. Cara Vasconcelles at Memorial Physician Services with complaints of persistent left ankle and lower leg pain, as well as low back pain. Dr. Vasconcelles assessed Petitioner with left ankle pain, left leg pain, and back pain. Petitioner was prescribed Metaxalone, Tramadol, an ankle air cast stabilizer brace, and a compression stocking. He underwent x-rays of his ankle and tibia-fibula on April 6, 2015, which were negative. Dr. Vasconcelles issued work restrictions for Petitioner on April 13, 2015, and Nurse Practitioner Andrea Beyers removed Petitioner from work on April 30, 2015. PX 4.

Petitioner presented to Dr. Barry Mulshine at the Orthopedic Center of Illinois on May 5, 2015. He reported intermittent swelling in his left lower leg, pain at both anteromedial and anterolateral, general pain and swelling increased with standing and walking. Upon physical examination, Dr. Mulshine noted that Petitioner ambulated without any assistive devices, but with a significant limp. He also noted painless range of motion across both hips and knees, good strength across the hips and knees, symmetric active motion across both ankles and hind feet, no significant swelling in the lower left leg, some tenderness fairly diffuse in the ankle, mild tenderness diffusely along the anterior compartment and mid tibia, no crepitus with passive motion across the ankle, and no instability. X-rays taken of the left foot were negative. Dr. Mulshine's assessment was persistent pain and intermittent swelling in the left lower leg five months following a motor vehicle accident with negative x-rays, negative electromyography, negative Doppler, and an MRI showing only some diffuse subcutaneous edema. Dr. Mulshine opined that there "does not seem to be any structural problem nor a neurological injury. I think the next area to work up would be vascular. This could represent a venous insufficiency. An ischemic problem would be less likely. I would recommend either vascular testing or consultation with a vascular surgeon." PX 4. Petitioner testified that at the time he presented to Dr. Mulshine, it was difficult for him to walk, his balance was poor, he was unable to bear weight on his left foot, and his gait was "kind of off".

On May 14, 2015, Petitioner presented to Dr. Michael Comerford at Memorial Physician Services for reevaluation of his left leg pain. He reported ongoing achy, sharp pain in the medial left

shin where the area of contusion occurred, as well as medial/posterior ankle pain and low back pain. Petitioner reported some relief of his left leg pain with utilization of a compression sock. Dr. Comerford assessed him with left leg pain, left ankle pain, and lumbar back pain. Petitioner was prescribed Ketorolac Tromethamine and Prednisone, a cast boot/shoe was ordered, and a physical therapy prescription was renewed relative to Petitioner's left leg and low back pain. PX 4. Petitioner was restricted from climbing stairs or ladders, working around high speed or moving machinery, lifting over ten pounds, and limited to desk job duties on May 26, 2015. PX 4.

Petitioner underwent physical therapy at Memorial beginning on June 2, 2015 relative to his left ankle. The physical therapist noted to "treat ONLY the ankle – therapy is not approved for back at this time."

On July 13, 2015, Petitioner presented to Dr. Vasconcelles with continued pain in his left leg and back following a motor vehicle accident on January 6, 2015 at work. He reported a sharp, shooting pain at times with a consistent dull ache that can radiate into both hips and sometimes down his right lower extremity. "He has had an EMG and MRI that did not show any disk herniation or fracture of his back to explain his pain." Dr. Vasconcelles assessed Petitioner with complex regional pain syndrome, lumbar degenerative disc disease, lumbar radiculopathy, lumbar back pain, smoker, and a cough. Petitioner was ordered to undergo a chest x-ray, physical therapy evaluation and treatment, and he was instructed to utilize Gabapentin. Dr. Vasconcelles removed Petitioner from work through July 14, 2015. On July 16, 2015, Petitioner was removed from work until July 30, 2015. PX 4. On July 30, 2015, Petitioner was restricted from operating mobile equipment and limited to desk tasks that allowed "him to be sitting more than walking" until his "back and leg pain resolves." PX 6.

Petitioner testified that he has experienced low back pain since its onset on the night of January 7, 2015. He stated that his pain interferences with his activities, and he cannot vacuum or sweep the floor. Petitioner is presently undergoing medical treatment for his left foot and ankle, and has also begun a physical therapy program at Memorial Rehabilitation relative to his low back that is paid by his group health insurance through Respondent. Petitioner stated that Respondent has not authorized physical therapy for his low back at any time following his work accident. He has received three physical therapy treatment visits to his low back, though he has not received any bills for same to date, and he stated that physical therapy is somewhat improving the condition of his back. Petitioner testified that he continues to have an altered gait that he explained is worse at times than others and he continues to work in a light duty capacity for Respondent.

Captain Rutledge testified at Arbitration. She is the administrator of Respondent's facility and oversees an eighty-six bed facility for drug addicted men. Captain Rutledge testified that Respondent also operates a store and a fleet of trucks, and she herself manages five remote locations. She acknowledged that she is not in the office at all times. Captain Rutledge testified that she recalled Petitioner's date of accident and she stated that she checked on Petitioner and another of Respondent's drivers who were both present in the emergency room on January 6, 2015. Captain Rutledge testified that she was unable to observe whether Petitioner ambulated with a limb on that date because he was on a gurney in the hallway of the hospital upon her arrival. She was not present when he was attended to by a nurse or physician, and she was not present when Petitioner was examined. Captain Rutledge testified that Petitioner returned to work on January 9, 2015, and that Respondent instructed him to seek additional medical treatment at that time because he was in a significant amount of pain in his left leg and he was limping. She stated that she observed his leg

and it was still swollen at that time. Captain Rutledge was unable to recall whether he complained to her about anything other than his left leg hurting, but she stated that she reviewed the discharge sheet from the hospital of January 9, 2015 that indicated he also complained of back pain. Captain Rutledge stated that Respondent accommodated Petitioner's restrictions, when indicated, and she testified that he performed some lifting within his restrictions with assistance on the docks. She testified that presently, Petitioner is working with restrictions or no lifting as a dispatcher and in that position, Petitioner watches trucks while sitting in a chair and takes phone calls. Since Petitioner has returned to work, Captain Rutledge has noticed that Petitioner walks with an altered gait that she states has varying degrees, as it is sometimes worse and sometimes better. She described his gait as at times very halting, and at other times, the altered gait is unnoticeable. Captain Rutledge testified that Petitioner wears an elastic sock for his left lower extremity condition and she stated that Respondent is aware that Petitioner has repeatedly complained of low back pain.

OPINION AND ORDER

The parties stipulated that on January 6, 2015, Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent. Arb. X 1.

In regard to disputed issue (F), Respondent does not dispute the causal relatedness of Petitioner's left lower extremity condition to his work accident. Respondent disputes the causal connection between Petitioner's low back condition and his work accident.

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64 (1982). "An independent intervening cause has been held to be one which breaks the chain of causation between a work-related injury and an ensuing disability or injury...Thus, if a nonemployment-related factor is a contributing cause, with the compensable injury, in an ensuing injury or disability, it does not constitute an 'independent intervening cause' breaking the causal connection where it is not brought about by claimant's intentional or negligent misconduct." *International Harvester Co. v. Industrial Comm'n*, 46 Ill.2d 238, 245-247 (1970).

The Arbitrator concludes that Petitioner's current condition of ill-being in his low back is causally related to his work accident of January 6, 2015. In so finding, the Arbitrator notes that Petitioner was working without restrictions at the time of his work accident and performed job tasks as assistant dock foreman and truck driver in the six months preceding his injury that required lifting, carrying, bending and stooping. Following his work accident, however, Petitioner testified that he suffered an onset of low back pain that began one day following the motor vehicle accident, which has persisted to the present. Although Respondent contends that the record is devoid of any mention of Petitioner's low back complaints between January 9, 2015 and February 9, 2015, the Arbitrator notes that Petitioner complained of low back pain "that has not improved much" upon presentation to Dr. Owolabi on January 29, 2015. PX 3, RX 5. While Petitioner's complaints of low back pain are not present in every treatment record subsequent to January 9, 2015, Petitioner reported a history of back pain following his motor vehicle accident to Memorial Medial Center, Dr. Owolabi, Dr. Comerford, and Dr. Vasconcelles that is consistent with his testimony at Arbitration, and his treating medical records corroborate his continued complaints of back pain.

The Arbitrator finds that Petitioner's medical records demonstrate that the box-lifting incident of February 8, 2015 was not sufficient to interrupt the causal connection between his current condition of ill-being in his low back and his work accident of January 6, 2015. Although Petitioner may have experienced symptomatology as a result of the lifting incident that contributed to his condition, the Arbitrator notes that Petitioner's complaints of low back pain are clearly represented in his treatment records beginning on January 9, 2015. Petitioner's testimony that he experienced sharp pain in his low back following his work accident and then a dull ache as a result of the lifting incident of February 8, 2015 in addition to the sharp pain already present demonstrates that Petitioner's work accident continues to be a factor in his current low back condition. Petitioner's testimony is supported by Dr. Owolabi's treatment record of March 6, 2015 in which, subsequent to the box-lifting incident of February 8, 2015, Petitioner continued to relate his low back pain to his work accident of January 6, 2015, rather than to the box-lifting incident (PX 3), as well as by Dr. Vasconcelles record of July 13, 2015, wherein Petitioner presented with complaints of back pain that had persisted since his motor vehicle accident at work on January 6, 2015. PX 4. The Arbitrator finds that the histories of February 9, 2015 and March 26, 2015 regarding Petitioner's box-lifting incident are undermined by the subsequent histories of March 6, 2015 and July 13, 2015, respectively, in which Petitioner reported low back pain since his work accident of January 6, 2015. PX 3, 4. To rely upon the histories contained in Dr. Owolabi's notes of February 9, 2015 and March 26, 2015 to find that his current low back condition is solely resultant from the box-lifting incident of February 8, 2015, and that his work accident of January 6, 2015 is not a factor in his current low back condition, would necessitate the Arbitrator ignore the history provided to Dr. Owolabi by Petitioner on January 29, 2015, more than a week prior to the box-lifting incident, wherein Petitioner reported "back pain that has not improved much" (PX 3), the two histories of low back pain reported by Petitioner on January 9, 2015 (PX 1), as well as that of March 6, 2015 and July 13, 2015 in which Petitioner reported low back pain since the work accident. PX 3, 4. In light of the aforementioned, the Arbitrator finds insufficient evidence in the record to warrant a conclusion that Petitioner's lifting incident of February 8, 2015 broke the causal connection chain between his work accident of January 6, 2015 and his current condition of ill-being in his low back.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner's current condition of ill-being in his low back is causally related to his work accident of January 6, 2015. The Arbitrator concludes that Petitioner's current condition of ill-being in his left foot and left leg is causally related to his work accident, as stipulated by the parties.

In regard to disputed issue (J) and in conjunction with the Arbitrator's conclusions as to causal connection, the Arbitrator finds Petitioner's care and treatment to be reasonable, necessary, and casually related to his work accident. Respondent shall pay all reasonable and necessary medical services, as provided in Sections 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 from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (K) and in conjunction with the Arbitrator's conclusions as to causal connection, the Arbitrator finds that Petitioner is not at maximum medical improvement and is in need of further medical care. Moreover, the Arbitrator finds that the need for prospective medical care to his low back, left foot, and left leg is causally related to the work accident of January 6, 2015. Respondent shall pay for all reasonable and necessary prospective medical treatment, including, but not limited to, physical therapy relative to Petitioner's low back condition.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Orlando Benau,

Petitioner,

vs.

NO: 15 WC 29314

CTA,

Respondent,

16IWCC0449

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 accicdent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 4, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1.00. 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: JUN 3 0 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:6/23/16
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

BENAU, ORLANDO
Employee/Petitioner

Case# **15WC029314**

16IWCC0449

CTA
Employer/Respondent

On 1/4/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0243 JAMES ELLIS GUMBINER & ASSOC
EDUARDO SALGADO
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

☐	Injured Workers' Benefit Fund (§4(d))
☐	Rate Adjustment Fund (§8(g)
☐	Second Injury Fund (§8(e)18)
☒	None of the above

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

ORLANDO BENAU
Employee/Petitioner

Case #15 WC 29314

v.

16IWCC0449

CTA
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on November 18, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☐ Prospective medical care?

FINDINGS

- On August 28, 2015, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of an injury was given to the respondent.
- In the year preceding the injury, the petitioner earned $68,265.60; the average weekly wage was $1,312.80.
- The parties agreed that the respondent paid $1,650.00 in non-occupational indemnity disability benefits.

ORDER:

- The petitioner's request for benefits is denied and his claim is dismissed.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E. Williams

Signature of Arbitrator

December 30, 2015

Date

JAN 4 – 2016

FINDINGS OF FACTS:

The petitioner, a right-hand dominant bus driver, sustained an injury on August 28, 2015, during an altercation. He received emergency care at Metro South and reported an altercation, punching, falling and left shoulder tingling and numbness. X-rays revealed an anterior-inferior dislocation of his left shoulder. After his shoulder was reduced, the petitioner was discharged. He returned to work and again sought emergency care. He was taken to Trinity Hospital where he reported feeling fine after the reduction but a return of his shoulder pain after sitting at a desk for three hours. He received care at Concentra for his left shoulder on September 1st and reported an improving sharp, throbbing left shoulder pain with radiation to his elbow. Dr. Markarian of Orthopedic Associates saw the petitioner on September 9th and opined that an MRI that day revealed an anterior-inferior labral tear with a little bit of capsular stretch. His assessment was a torn labrum and an axillary nerve neuropraxia. A CT scan on September 14th revealed blunting and irregularity involving the anterior/inferior glenoid with adjacent bone fragment and a Hill-Sachs deformity without evidence of a discrete fracture line.

The petitioner saw Dr. Suneela Harsoor on August 31st for left shoulder and back pain and was started on physical therapy. A nerve conduction study on October 16th was abnormal with evidence of a left-sided brachial plexus lesion, peripheral neuropathy and peripheral neuritis. Dr. Markarian recommended an arthroscopic capsular labral reconstruction on October 21st. The petitioner received physical therapy through November 13th.

FINDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on August 28, 2015, arising out of and in the course of his employment with the respondent. Video recordings made at the time of the altercation show that a male standing near the petitioner turned toward the exit, took a step toward the door but then turned back and spat toward an opening in the plexiglass shield between him and the driver's area and quickly left the bus. The petitioner opened the shield door and after a pause, ran off the bus and attacked the individual. After they separated, the individual walked away and the petitioner walked toward him and attacked him again. The petitioner was the aggressor and was not performing duties arising out of, incidental to or in furtherance of his employment.

The petitioner's injury was not the result of his attempt to protect his welfare or property or the passengers' or the respondent's welfare or property. The petitioner's act was retaliatory and solely for his own personal benefit or revenge. The injury to the petitioner was a result of a personal risk. Moreover, when petitioner left the bus to go after the individual who had exited the bus, he abandoned his employment duties and was no longer operating within the scope of his employment. Nor is it believable that the petitioner does not recall his aggressive actions. The petitioner is not believable or credible. The petitioner's request for benefits is denied and his claim is dismissed.

STATE OF ILLINOIS)
) SS.
COUNTY OF DuPAGE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHLEEN WANHALA,

Petitioner,

16IWCC0450

vs.

NO: 13 WC 8718

CDS GLOBAL LOGISTICS,

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, 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 disability 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 fact and Conclusions of Law

1. Petitioner testified she worked for Respondent full time since April 2007 auditing files. Every morning she retrieves e-mails, prints them out, and audits them to make sure all the information is correct. On slow days she will stamp files and do filing. For the first two hours of her day she is generally retrieving and printing the e-mails and then she would sit down and "enter everything." When she was working full time she would be using the keyboard constantly close to six hours a day. Currently, it is close to four hours.

2. In January 2012 she mentioned to her primary care provider, Dr. Morso, that she was having problems with her wrists, right worse than left. She is "very much" right handed. He referred Petitioner to Dr. Prinz, whom she was not able to see until March. She had injections, which only provided relief for two to three weeks.

3. Petitioner had carpal tunnel release surgery on her right wrist on September 5, 2012. When they took the bandages off she noticed her ring "finger didn't go all the way back" and she had "like trigger in [her] baby finger." She had not experienced these symptoms previously. She went to therapy, "but that did not work either." Petitioner had carpal tunnel release surgery on her left wrist on July 17, 2013. She did not have similar problems with her fingers after the left-sided surgery.

4. Petitioner returned to work on November 30, 2012 after her first surgery and worked up to her second surgery in July 2013. However, she only worked six hours a day, 30 hours a week. The reduction in hours was recommended by Dr. Prinz because the job was "putting too much strain" on her right hand. After the second surgery, Petitioner returned to work on September 24, 2013, but that was also on the reduced 30-hour week, due to the pain in her right hand, per instructions of Dr. Prinz. Respondent did not take issue with her reduced work schedule.

5. Petitioner also testified that the condition of the fingers in her right hand has gotten worse. She can only sleep for five hours. She takes a combination of Tramadol and a sleep aid. The medication worked initially, but not anymore. She last had injections in the fingers when she had the left carpal tunnel surgery. Currently, her fingers give her problems when she is filing. When she is typing she has to stop and hold her fingers "real tight to stop the pain." Dr. Prinz told her she could not have more injections. Petitioner wants the prospective surgery on her right ring and little fingers.

6. On cross examination, Petitioner agreed that she is diabetic. She has neuropathy in her legs. Dr. Prinz was aware that she is diabetic. She agreed that Dr. Prinz, Dr. Papierski, and Dr. Wilson, the doctor performing the EMG, all discussed the possibility of peripheral neuropathy. However, "each one told [her] something different."

7. Petitioner also agreed that she saw Dr. Papierski on November 25, 2013 at the request of Dr. Prinz. She also agreed that Dr. Papierski indicated that it might be possible that her condition was related to peripheral neuropathy due to her diabetes. Dr. Prinz also indicted that was a possibility after an EMG. Petitioner also agreed that she told Dr. Prinz that she "did not really buy this." The EMG showed she had bilateral carpal tunnel syndrome. The sensation in her hands is differently than the sensation in her legs. Dr. Prinz also indicated that she might have developed trigger finger from the carpal tunnel syndrome surgery.

8. Dr. Prinz discussed with her the prospective surgery. It is her understanding that he would take a tendon from her "middle finger and splice it" "to make these fingers work." Dr. Prinz indicated the surgery "should help."

9. On redirect examination, Petitioner testified Dr. Prinz has recommended she have the surgery. He told her that her current condition was more likely than not caused by her carpal tunnel syndrome. That statement was in his treating records. Petitioner thought she had diabetes since 2004. She did not have problems with her fingers prior to the carpal tunnel syndrome surgery. However, she has had problems with her legs.

10. The medical records establish that on March 30, 2012, Petitioner presented to Dr. Prinz with bilateral hand numbness and right hand pain for a couple of years, but which have recently worsened. She had a history of diabetic neuropathy. She had an EMG a couple of years previously which suggested right medial neuropathy and left ulnar neuropathy. Dr. Prinz noted that Petitioner "does a lot of office and computer work daily." Dr. Prinz diagnosed bilateral carpal tunnel syndrome. He would try splinting, and if that did not work he would consider surgical release.

11. As noted above, Dr. Prinz performed right carpal tunnel release on September 5, 2012. On November 19, 2012, Petitioner returned to Dr. Prinz who noted she still had problems with the right hand. She could not fully extend the 4th finger and some popping/locking in the 5th finger. Dr. Prinz indicated she might have flexor tensynovitis on the 4th and 5th finger which may be due to postoperative inflammation. He administered injections in the digits.

12. On March 12, 2013, Petitioner returned to Dr. Prinz. Her right hand was doing well but she her 4th and 5th finger symptoms returned. Her main problem was now her left hand. Dr. Prinz would perform left carpal tunnel release surgery. He issued an open letter opining that Petitioner's "condition are (*sic*) related to her work activities."

13. Petitioner continued to have problems with fingers in her right hand. On November 23, 2013, she presented to Dr. Papierski on referral from Dr. Prinz for evaluation of bilateral fingers tingling and inability to extend right ring finger post carpal tunnel release surgery. She had a BMI of 33.9.

14. Dr. Papierski noted that Petitioner's symptoms were "not increased with carpal tunnel pressure test. This suggests that numbness is due to another entity, and [he suspected] there may be diabetic peripheral neuropathy." However, she also may have carpal tunnel syndrome. He recommended a repeat EMG, and if that were equivocal he recommended an MRI. The MRI could be helpful in diagnosing cubital tunnel syndrome or possible diabetic peripheral neuropathy and provide an opportunity to assess the interosseous nerve to the right ring finger.

15. On June 12, 2014, Petitioner had an EMG. According to the interpretation by Dr. Wilson, the EMS showed "the extensor weakness appears to be due to a neuropathic process, probably secondary to diabetes, there is evidence for inflammatory neuropathy, which is likely affecting the nerve branch of the affected fascicle."

16. On June 24, 2014, Petitioner returned to Dr. Prinz who reviewed the EMG and discussed the results with Petitioner. Dr. Wilson thought her extensor weakness appeared to be from a diabetic neuropathic process. Petitioner was "not really buying this." Dr. Prinz told her the presentation was somewhat unusual and certainly quite possibly could be from a neuropathic process.

17. Dr. Prinz also noted that flexor tensynovitis could develop independently of carpal tunnel syndrome in diabetic patients. However, due to the temporal proximity it was also possible she developed trigger digit because of a change in dynamics of flexor tendons postop. He wrote that "this is not a universally accepted concept" and many people do not accept the association between carpal tunnel syndrome surgery and trigger finger. "Again some of her symptoms may have multifactorial etiology."

18. On September 24, 2014, at the request of Respondent, Petitioner presented to Dr. Cohen for a medical examination pursuant to Section 12 of the Act. Dr. Cohen had performed a previous examination but indicated his opinion was of limited value because he was not provided with previous medical records, which he subsequently received. Dr. Cohen continued to believe Petitioner was at maximum medical improvement from her carpal tunnel surgeries. "There does not appear to be any evidence of a continuing peripheral compressive neuropathy. Her electrical studies suggest that her extensor tendon weakness may be due in part to diabetic peripheral neuropathy."

19. In addition, Dr. Cohen did not see any evidence to indicate surgery for her ring finger extension. In his clinical exam he did not "see any evidence that she has stenosing tensynovitis or her ring or small fingers," which would suggest the need for release surgery. In addition, the cause of stenosing tensynovitis is idiopathic in the vast majority of cases and even if she did have the condition the vast majority of those cases resolve with injections. He also saw no evidence that would associate that possible condition and her work activities.

20. Dr. Cohen's diagnosis continued to be "atypical upper extremity pain." He did not have a specific diagnosis to account for her global complaints. "She may well have a diabetic peripheral neuropathy" which "can lead to neuropathic-type pain in the extremity." He saw no contraindication that Petitioner could not work in her regular job.

The Arbitrator found that Petitioner sustained her burden of proving that her work activities caused both her bilateral carpal tunnel syndrome and right sided tensynovitis/trigger fingers in the right hand. On the issue of carpal tunnel syndrome, the Arbitrator noted that Dr. Prinz had opined that her condition was causally related to her work activities. He also noted that Respondent had not presented any countervailing medical opinion concerning causation. On the issue of tensynovitis in the right-hand fingers, the Arbitrator found the causation opinion of Dr. Prinz more persuasive than those of other doctors.

The Commission agrees with the determination of the Arbitrator regarding Petitioner's bilateral carpal tunnel syndrome. The Arbitrator is correct that Respondent did not present any medical causation opinion countering that of Dr. Prinz. In addition, the Commission also notes that Respondent apparently accepted liability for the underlying bilateral carpal tunnel syndrome. It apparently paid all associated medical expenses and temporary total/partial disability benefits, and only began to dispute liability after Petitioner started to relate her tensynovitis/trigger fingers to her work activities. Therefore, the Commission affirms that portion of the Decision of the Arbitrator finding Petitioner sustained her burden of proving her bilateral carpal tunnel syndrome was causally related to her work activities and his award of benefits associated with that condition.

On the other hand, the Commission disagrees with the conclusion of the Arbitrator that Petitioner sustained her burden of proving her right-handed tensynovitis/trigger fingers were causally related to her work activities. After his Section 12 medical examination, Dr. Cohen noted that "there does not appear to be any evidence of a continuing peripheral compressive neuropathy. Her electrical studies suggest that her extensor tendon weakness may be due in part to diabetic peripheral neuropathy." In addition, he opined Petitioner "may well have a diabetic peripheral neuropathy" which "can lead to neuropathic-type pain in the extremity." Similarly, two of Petitioner's treating doctors suggested that her current condition of tensynovitis/trigger fingers appeared to be more likely related to diabetic peripheral neuropathy than secondary to carpal tunnel syndrome. Specifically, Dr. Papierski noted that Petitioner's symptoms were "not increased with carpal tunnel pressure test. This suggests that numbness is due to another entity, and [he suspected] there may be diabetic peripheral neuropathy." Likewise in interpreting her EMG, Dr. Wilson believed the EMS showed "the extensor weakness appears to be due to a neuropathic process, probably secondary to diabetes, there is evidence for inflammatory neuropathy, which is likely affecting the nerve branch of the affected fascicle."

Finally, the causation opinion of Dr. Prinz is fundamentally equivocal. Dr. Prinz based his causation opinion primarily on the temporal proximity of the tensynovitis symptoms to his first carpal tunnel release surgery. He specifically indicated that his theorized association "is not a universally accepted concept" and many people do not accept the association between carpal tunnel syndrome surgery and trigger finger. Finally, Dr. Prinz told Petitioner that the presentation was somewhat unusual, certainly quite possibly could be from a neuropathic process, and noted that flexor tensynovitis could develop independently of carpal tunnel syndrome in diabetic patients.

16IWCC0450

Because the Commission finds that Petitioner did not prove her tensynovitis/trigger fingers condition is casually related to her work activities, we reverse those benefits awarded as a result of those conditions. On the issue of medical expenses, the Arbitrator awarded Petitioner all medical expenses incurred to date as well as prospective treatment for her tensynovitis/trigger fingers. The Commission finds October 8, 2013 to be an appropriate date to terminate medical. At that time Dr. Prinz evaluated Petitioner after she returned to work on September 24, 2013 after the second carpal tunnel surgery. The Commission finds that evaluation of her condition after her initial return to work is appropriate and related to her underlying carpal tunnel syndrome. Thereafter, her treatment appears to have been related to her tensynovitis/trigger finger condition, which is not compensable. Obviously, the Commission also vacates the Arbitrator's award of prospective treatment for Petitioner's tensynovitis/trigger fingers.

The Arbitrator awarded Petitioner temporary partial disability benefits of $88.20 for 80&3/7 weeks representing the diminution of income from the time Petitioner returned to work in a diminished capacity after the second carpal tunnel surgery through the date of arbitration. The Commission cannot determine what, if any, portion of the temporary disability benefit is attributable to Petitioner's carpal tunnel syndrome, which is compensable, and what, if any, portion is attributable to the tensynovitis/trigger finger, which is not. The Commission notes that because the matter was arbitrated pursuant to Section 19(b) of the Act, the matter will necessarily be remanded to the Arbitrator for further proceedings. Therefore, the Commission vacates the Arbitrator's award of temporary partial disability benefits and remands the matter to the Arbitrator for determination of which such benefits are related to her condition of bilateral carpal tunnel syndrome and which are therefore appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award of sum of $88.20 per week for a period of 80&3/7 weeks under §8(a) is vacated, and that the matter is remanded to the Arbitrator for a determination of appropriate temporary disability compensation, if any, or of compensation for permanent disability, if any, consistent with this Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay all medical expenses incurred through October 8, 2013 under §8(a), subject to the applicable medical fee schedule pursuant to §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.

16IWCC0450

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 $$25,000.00. 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: JUN 3 0 2016

Charles J. DeVriendt

RWW/dw
0-6/22/16
46

Joshua D. Luskin

DISSENT IN PART & CONCURRENCE IN PART

I concur with the decision and the reasoning of the majority in finding that Petitioner failed to prove that the current condition of ill being regarding her tensynovitis/trigger fingers in her right hand were causally related with her work activities and its decision to reverse the Decision of the Arbitrator on that issue. Therefore, I concur with that portion of the Decision of the majority. However, I would have also found that Petitioner did not sustain her burden of proving that the underlying condition of her bilateral carpal tunnel syndrome was causally related to her work activities, reversed the Decision of the Arbitrator on that issue as well, and denied compensation entirely. Therefore, I respectfully dissent from the portion of the decision of the majority affirming Decision of the Arbitrator regarding causation of Petitioner's bilateral carpal tunnel syndrome.

First, Petitioner had significant preexisting risk factors for developing carpal tunnel syndrome. Her age (60), her gender (female), and her obesity (BMI of 33.9), are all known risk factors for developing carpal tunnel syndrome. In addition, most significantly Petitioner had advanced diabetes. Not only is that condition a very strong risk factor in developing and/or aggravating to carpal tunnel syndrome, Petitioner admitted the condition actually resulted in diabetic peripheral neuropathy in her legs, and as opined by Drs. Cohen, Papierski, and Wilson, according to the Decision by the Commission as well, likely also caused her tensynovitis/trigger fingers.

Second, Petitioner did not prove that her work activities were the type that would likely cause the development or aggravation of carpal tunnels syndrome. All she testified to was that she worked on a computer for about six hours a day. The job description provided by Respondent, upon which the Arbitrator at least partially relied, also does not appear to support the proposition that Petitioner engaged in the type of activities that would cause or aggravate carpal tunnel syndrome. The job description indicates only that Petitioner was responsible for "working through multiple data bases" and "imputing data into the company systems." It does not specify the percentage of time of Petitioner's work day is devoted to those activities. In my opinion, keyboarding alone is not sufficient to establish causation or aggravation of carpal tunnel syndrome. There was no evidence that Petitioner's work activities included any forceful grasping/gripping, extreme wrist flexion/extension, or any vibratory impact, whatsoever. Therefore, I conclude that Petitioner has not sustained her burden of proving that her work activities were causally connected to any of her conditions of ill being.

For the reasons outlined above I respectfully dissent from the portion of the decision of the majority affirming the Decision of the Arbitrator finding Petitioner proved her bilateral carpal tunnel syndrome was causally related to her work activities. I would have reversed the Decision of the Arbitrator and denied compensation entirely.

Ruth W. White

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0450

WANHALA, KATHLEEN
Employee/Petitioner

Case# **13WC008718**

CDS GLOBAL LOGISTICS
Employer/Respondent

On 9/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

3098 MICHAEL D NICHOLSON LTD
7111 W HIGGINS
CHICAGO, IL 60656

0560 WIEDNER & McAULIFFE LTD
PATRICK J MORRIS
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

16IWCC0450

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)

Kathleen Wanhala
Employee/Petitioner

v.

CDS Global Logistics
Employer/Respondent

Case # 13 WC 08718

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Wheaton** on March 26, 2015. Thereafter, proofs were closed in the city of **Geneva** on April 15, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to Respondent?

F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?

G. ☐ What were Petitioner's earnings?

H. ☐ What was Petitioner's age at the time of the accident?

I. ☐ What was Petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. ☒ 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, ***9/4/12***, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this alleged accident ***was*** given to Respondent.

Petitioner's current conditions of ill-being ***are*** causally related to the accident.

In the year preceding the injury, Petitioner earned ***$33,093.84***; the average weekly wage was ***$636.00***.

On the date of accident, Petitioner was ***60*** years of age, ***married*** with ***0*** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of ***$9,394.75*** for TTD, ***$374.75*** for TPD, and ***0.00*** for maintenance for a total indemnity credit of ***$9,769.50***. All TTD benefits have been paid (9/5/12 – 11/29/12 and 7/17/13 – 9/23/13).

Respondent is entitled to a credit for all medical bills paid.

Respondent is entitled to a credit for any and all medical bills paid by the group health insurance carrier under Section 8(j) of the Act.

ORDER

RESPONDENT SHALL PAY PETITIONER TPD BENEFITS OF $88.20/WEEK FOR 80-3/7 WEEKS, FROM SEPTEMBER 24, 2013 THROUGH MARCH 26, 2015, PURSUANT TO SECTION 8(a) of the Act.

RESPONDENT SHALL AUTHORIZE AND PAY FOR PROSPECTIVE MEDICAL CARE FOR PETITIONER IN THE FORM OF TRIGGER DIGIT RELEASES OF THE RIGHT 4TH AND 5TH FINGERS, IN ACCORDANCE WITH SECTION 8(a) and subject to Section 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

September 26, 2015
Date

SEP 28 2015

ICArbDec19(b)

FINDINGS OF FACT:

On September 4, 2012, Kathleen Wanhala (*"Petitioner"*) was employed with CDS Global Logistics (*"Respondent"*). She testified that she has been employed by the company since April 2007. During the course of her testimony, Petitioner did not identify her specific job title. However the Arbitrator notes the written job description introduced into evidence by Respondent indicates Petitioner's job title: "Import Operations Agent." (R Ex 7) Petitioner testified that she is responsible for auditing files, which involves going through emails to determine whether the figures, locations, and other information involving various shipments are correct. Respondent is a logistics company. She testified that during the first two hours of her shift, she is usually retrieving information and printing emails. Petitioner testified that she would spend 6 hours per day on the computer keyboard, but now that she is part time, 4 hours a day. Petitioner is diabetic and testified that she was diagnosed with this condition in 2004.

According to Petitioner, in January 2012 she mentioned that she was having problems with her wrists, right more than left. Petitioner is right-hand dominant. She testified that she would experience pain beneath her palms on the palmar side of her hands that ran up through the middle of her palms. In January 2012, she sought initial medical care with her primary care physician, Dr. Emanuele Morso. Dr. Morso then referred her to Paul T. Prinz, M.D. (P Ex 1)

Petitioner began treating with Dr. Prinz on or about March 30, 2012. (P Ex 1) Dr. Prinz's chart note on that date indicates that Petitioner presents for bilateral hand numbness and right-sided hand pain that *"has been going on now for a couple of years."* He added: *"She feels that they have worsened."* He noted: *"Petitioner has a history of diabetic neuropathy."* He further noted that Petitioner had an EMG done a couple of years ago and the report suggests right-sided median neuropathy, left-sided ulnar neuropathy and no cervical neuropathy. She has not had surgery on her hands or wrists before. She feels that all of the fingertips get numb but that the fifth fingers are less symptomatic than the other fingers. Upon examining Petitioner, Dr. Prinz found, *inter alia*, positive Tinel's test bilaterally, positive Phalen's test bilaterally, and positive carpal compression bilaterally. Dr. Prinz then opined: "At this point in time, I feel she may have symptoms from a carpal tunnel syndrome bilaterally. She also has a history of DM and neuropathy." He prescribed wrist cock-up splints and advised her to wear these at night and for a few hours while at rest during the day. Dr. Prinz opined that non-operative splinting would be the first choice as she does have a history of diabetes and there is a chance that a carpal tunnel release may not completely alleviate her symptoms as some symptoms may be from diabetic neuropathy. (P Ex 1)

Petitioner testified that during the treatment process she received *"shots"* in her right hand, but that such shots did not work.

Petitioner underwent carpal tunnel release surgery on her right hand on September 5, 2012. Dr. Prinz performed the surgery. (P Ex 1) She testified that when the doctor took the bandages off after the surgery, she noticed that her right ring finger *"didn't go all the way back"* and that she had triggering in her right small finger. Petitioner further testified that she did not have these problems before the right

carpal tunnel release. Petitioner testified that post-operatively, Dr. Prinz prescribed physical therapy, splints and a Velcro brace to keep her two fingers together.

Petitioner testified that she was off work from September 5, 2012 through November 29, 2012. Respondent paid TTD benefits to Petitioner during this period. (R Ex 8, A Ex 1) Petitioner returned to work for Respondent on November 30, 2012, and she continued working until July 16, 2013. Petitioner testified that she worked *"constantly"* up to the time of the left carpal tunnel release surgery.

Petitioner testified that from November 30, 2012 through July 16, 2013, Dr. Prinz cut her work hours down to 6 hours a day. She testified that she experienced right hand pain from using the mouse all day at work. Petitioner further testified that no one at the company told her to work more than 6 hours a day. Petitioner testified that she still works 6 hours a day.

On July 17, 2013, Petitioner underwent carpal tunnel release surgery on her left hand, as well as steroid injection of her right 4th and 5th trigger digits. (P Ex 1) Petitioner testified that after recovering from the left carpal tunnel release, she experienced improvement in her left hand and no triggering in the fingers of her left hand. However, Petitioner testified, she continued to have problems with her right hand.

Petitioner was off work, and Respondent paid TTD benefits to Petitioner from July 17, 2013 through September 23, 2013. (R Ex 8)

Petitioner testified that she went back to work on September 24, 2013 and that she still worked 6 hours a day because of her right hand pain. Dr. Prinz's October 8, 2013 chart note indicates that Petitioner told him that she noted some tingling in the fingers at the end of the day. The doctor wrote: "She returned to work on 9-24-13. She is working 6 hour days . . . We discussed having the patient cut back on work. She states she would like to continue to work at this time. We will keep her at 6 hour work days." (P Ex 1)

Respondent paid TPD benefits to Petitioner for the period September 24, 2013 through November 15, 2013. (R Ex 8)

On July 23, 2013, Petitioner followed up with Dr. Prinz for a post-operative office visit. At that time she stated that she noticed less numbness and burning in her left hand. Dr. Prinz also examined Petitioner's right hand, and opined that the examination revealed no triggering and no tenderness at the A1 pulleys of the right 4th and 5th fingers.

At her August 20, 2013 follow-up visit to Dr. Prinz, Petitioner commented that she noted improvement with respect to numbness in the right hand. She also noted some hypothenar pillar pain in the hand when she is pushing off with the hand. Upon examination, Dr. Prinz healed incision in the left hand, no associated erythema, some hypersensitivity at the hypothenar pillar, and no severe edema. (P Ex 1)

At the September 10, 2013 follow-up visit to Dr. Prinz, Petitioner commented that she was no longer waking up during the night due to hand pain. Also, Petitioner noted mild residual numbness but

further noted that it is not painful like it was before the surgery. Upon examination, Dr. Prinz found, *inter alia*, diminished swelling of the left hand and also diminished grip strength on the left compared to the right. (P Ex 1)

On November 5, 2013, Petitioner followed up with Dr. Prinz with various complaints, mostly involving her right hand. She noted that although the 4th and 5th flexor sheath injections helped her, she has experienced a recurrence of symptoms. Petitioner complained of bilateral mild numbness in the median nerve distribution as well as some locking of the 5th finger at the MP joint, and an inability to completely extend the 4th finger at the MP joint. Pursuant to his physical exam Dr. Prinz noted no significant tenderness to palpation of the right 4th and 5th A1 pulleys. He also commented that there was "no true locking" seen on exam, and crepitus noted at the right 4th and 5th finger A1 pulleys was mild. According to Dr. Prinz, Petitioner did exhibit the ability to "voluntarily" catch or lock the 5th finger, but it did not appear to Dr. Prinz to be true triggering, but rather some voluntary subluxation at the MP joint. Dr. Prinz commented that this was a "[s]omewhat unusual exam," with limited active extension of the right 4th finger, but good passive extension of the right 4th finger. According to Dr. Prinz:

> *"Some of this could be from diabetic neuropathy. At this point in time she still has multiple complaints. I am not really convinced that there is anything surgical that I can do to help her. Trigger release in my opinion is a reasonable option but some of her signs and symptoms are somewhat unusual. Exploration of extensor tendons in my estimation may not turn out to be fruitful. I told her that I think the risks of surgery may outweigh the benefits but because she is complaining of this issue I think it's wisest to get a second opinion."* (P Ex 1)

On November 25, 2013, pursuant to a referral from Dr. Prinz, Petitioner sought a second from Paul E. Papierski, M.D. (R Ex 9) Dr. Papierski noted that Petitioner presented with persistent numbness in the fingertips of her bilateral hands status post bilateral carpal tunnel release surgery. He noted that Petitioner's symptoms were not increased with carpal tunnel pressure testing, and that this result suggested that numbness is due to some other entity; he suspected there may be diabetic peripheral neuropathy. There may be cubital tunnel syndrome. Dr. Papierski also noted that there may be a neurologic problem of the branch of the posterior interosseous nerve. More unusually, he opined, there could be multiple sclerosis. Dr. Papierski recommended repeat electro-diagnostic testing. (R Ex 9)

On January 8, 2014, Petitioner underwent a Section 12 examination at Respondent's request with Mark S. Cohen, M.D. (R Ex 1) Dr. Cohen wrote: "Unfortunately, the medical records in this case were not obtained in time to be reviewed. Thus the following information was obtained from Ms. Wanhala in the office today." The doctor noted that Petitioner performs predominantly clerical and data entry activities and has worked in this capacity for approximately 7 years. Dr. Cohen noted Petitioner's past medical history as significant for diabetes, increased cholesterol, and sarcoidosis, and that she was taking medications for hypertension, cholesterol, diabetes, and pain, as well as estrogen and Gabapentin. On physical examination, Dr. Cohen was unable to appreciate any evidence of extensor tendon subluxation at the metacarpophalangeal joint. Moreover Petitioner's sensory exam was *"quite variable,"* in that Petitioner answered *"2"* when touched with 1 point, and *"1"* when touched with 2 points. Petitioner

also exhibited equal grip and pinch strength as between her bilateral hands. According to Dr. Cohen, Petitioner's subjective complaints were out of proportion to the objective findings on exam. Dr. Cohen stated that Petitioner did not have any positive provocative tests for carpal tunnel syndrome, as both median nerve and Phalen tests were negative, bilaterally. Petitioner did have tenderness over the Lister tubercle. But according to Dr. Cohen, several examination findings were "difficult to explain on a simple anatomic basis." As such, Dr. Cohen opined, he did not have a diagnosis to account for Petitioner's "global" right upper extremity complaints, and he specifically did not have a diagnosis for Petitioner's inability to hyperextend her right ring finger at the metacarpophalangeal joint. Dr. Cohen's stated that the current diagnosis involves atypical and global pain to both upper extremities with no specific diagnosis. Dr. Cohen stated that his opinions in this case are limited as he has not been able to review any of the previous medical records. Dr. Cohen wrote that the diagnosis appears to be bilateral carpal tunnel syndrome with bilateral carpal tunnel releases having been performed. In addition, Ms. Wanhala has bilateral complaints for which he cannot provide a diagnosis. He found that her subjective complaints are somewhat out of proportion to the objective findings. These could suggest a functional (nonorganic) component to her complaints. Dr. Cohen stated that he knew of no "injury" that occurred at work. He opined that Petitioner could work full duty with no restrictions, recommended a home stretching and strengthening program, and declared her to be at MMI. (R Ex 1)

On February 25, 2014, Petitioner followed up with Dr. Prinz, who noted Dr. Papierski's prior differential diagnoses of diabetic peripheral neuropathy, cubital tunnel syndrome, multiple sclerosis, and posterior interosseous nerve palsy. As of this date, Petitioner stated that the numbness in her bilateral hands had essentially gone away status post bilateral carpal tunnel release surgery. As to Petitioner's ongoing right 4th and 5th finger complaints, Dr. Prinz ordered the EMG in accordance with Dr. Papierski's recommendations. (P Ex 1)

Petitioner had the upper extremity EMG on June 12, 2014, which was performed by John R. Wilson, M.D. According to Dr. Wilson, the study revealed that:

> *"The extensor weakness appears to be due to a neuropathic process, probably secondary to diabetes. There is evidence for inflammatory neuropathy, which is likely affecting the nerve branch to the affected fascicle."* (R Ex 3)

Dr. Prinz reviewed the results of the EMG with Petitioner on June 24, 2014. He noted Dr. Wilson's opinion that Petitioner's complaints were likely due to a peripheral diabetic neuropathy. According to Dr. Prinz, upon hearing the opinions of Dr. Wilson, Petitioner "is not really buying this." Dr. Prinz advised Petitioner that hers was a somewhat unusual presentation of symptoms, and it is certainly possible that these symptoms are from a neuropathic process, although he stated that her symptom complex was not really consistent with a neuropathic process and could possibly be concomitant flexor tenosynovitis and a neuropathic process. Dr. Prinz discussed the possibility of surgery with Petitioner, but he cautioned that based on the "new information" he could "not guarantee" that the surgery would help to alleviate her complaints. Dr. Prinz wrote:

"I told her in my estimation flexor tenosynovitis or trigger digits can develop independently of carpal tunnel syndrome in a diabetic patient. However because of the temporal relationship I do believe that it is possible that she developed trigger digits status post-surgery because of change in the dynamics of flexor tendons. This is not a universally accepted concept . . . I was very clear with her that many people do not believe that trigger digits can occur after carpal tunnel surgery because of altered dynamics of flexor tendons, and that in my opinion it is difficult to determine definitively why she is having her symptoms. Again some of her symptoms may have multifactorial etiology." (R Ex 4) (P Ex 1)

As of August 19, 2014, Petitioner continued to complain to Dr. Prinz about her inability to fully extend her right 4th and 5th fingers. Dr. Prinz noted Dr. Papierski's and Dr. Wilson's opinions that Petitioner's ongoing complaints were more likely due to a peripheral diabetic neuropathy. According to Dr. Prinz, *"She* [Petitioner] *is not in agreement with this diagnosis."* On physical examination Dr. Prinz stated that he did not appreciate true triggering, but Petitioner stated that the same would occur in the morning and sometimes at night. He reiterated that he felt that her symptomatology was *"multifactorial"* and that *"the lack of full extension at the 4th MCP certainly may be related to neuropathic process."* Notwithstanding the foregoing, Dr. Prinz opined: *"the tenderness at the A1 pulley and symptoms of triggering in my opinion are more likely from tenosynovitis. Therefore with trigger digit release it is possible some symptoms will be improved but I think it unlikely she will regain full active extension at the fourth finger."* (P Ex 1)

At Respondent's request, Dr. Cohen authored an addendum to his prior Section 12 examination report on October 1, 2014. (R Ex 6) Pursuant to the addendum report, Dr. Cohen noted that he had been asked to review updated medical records, a written job analysis report (R Ex 7), and updated information concerning the possibility of a pending change in work responsibilities for Petitioner's job as an Import Operations Agent for Respondent. Dr. Cohen reiterated his belief that Petitioner is at MMI pursuant to her prior carpal tunnel release surgeries. As to Petitioner's complaints involving her right 4th and 5th fingers, Dr. Cohen stated that his prior examination did not reveal any evidence of stenosing tenosynovitis of Petitioner's ring and small fingers, and so he had a *"difficult time agreeing with right ring and small finger 1st annular pulley releases."* Moreover, according to Dr. Cohen, even if Petitioner did have this condition, it would typically be treated conservatively. He noted that the vast majority of these cases resolve with a cortisone injection to the flexor tendon sheath. He stated that the condition of stenosing tenosynovitis is idiopathic in the great majority of cases, and is often seen in association with diabetes mellitus. As such, he opined that Petitioner's alleged stenosing tenosynovitis is not related to her job duties with Respondent. He reiterated his prior diagnosis of atypical upper extremity pain. Dr. Cohen stated that Petitioner *"may very well have a diabetic peripheral neuropathy,"* but regardless of whether she does or does not have this condition, he opined that Petitioner is capable of working full duty with no restrictions – even taking into account the possibility of increased job responsibilities. (R Ex 6)

The Arbitrator notes that according to Dr. Prinz, Petitioner contacted him by telephone on or about March 11, 2015. She explained that she was *"going before a judge"* and needed an explanation of

why she is on work restrictions, and the approximate cost of the trigger digit release surgeries on the 4th and 5th fingers of her right hand. At that time Dr. Prinz reminded Petitioner that he had not seen her since August of 2014, and that he would not schedule any surgery for her without reassessing her first. (P Ex 1)

On March 19, 2015, Dr. Prinz authored a brief narrative in which he stated that he was recommending A1 pulley release and possible flexor tenosynovectomy involving the right 3rd, 4th, and 5th fingers. (*The Arbitrator notes that this notation marks the first time that any doctor has mentioned Petitioner's right 3rd finger as being symptomatic.*) He stated that he could not provide a definitive figure as to the cost of the surgery, but he did provide a rough estimate of approximately $3,000.00 to $6,000.00. (P Ex 1)

Petitioner testified to ongoing complaints involving her right 4th and 5th fingers. She testified that her fingers are painful if she's typing a lot and she has cramps in her fingers if she's filing. (TX 21) She testified that Dr. Prinz has offered a surgery which, according to Petitioner, he believes will alleviate Petitioner's right 4th and 5th finger symptoms.

Petitioner testified that she previously had a diabetic peripheral neuropathy in her legs. However she did not believe that her current right hand and finger complaints are related to a peripheral neuropathy brought on by her diabetes, as has been suggested by various physicians, because her right hand and fingers do not feel like it does in her legs. Petitioner testified that she is still employed by Respondent and that she has group health insurance coverage through United HealthCare, which she obtained through her employment by Respondent.

CONCLUSIONS OF LAW:

In support of his findings and conclusions with regard to issues (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", and (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds as follows:

Petitioner testified that she has been employed with the Respondent since April 2007. She further testified that she is responsible for auditing files, which involves going through emails to determine whether the figures, locations, and other information involving various shipments are correct. Respondent is a logistics company. She testified that during the first two hours of her shift, she is usually retrieving information and printing out emails. Petitioner testified that she would spend 6 hours per day on the computer keyboard, but now that she is part time, 4 hours a day. Petitioner testified that she is diabetic, and was diagnosed with this condition in 2004.

As an Import Operations Agent for Respondent, Petitioner's essential duties and responsibilities include, but are not limited to, the following:

1. Clears shipments through U.S. Customs following all import shipment documentation procedures
2. Works through multiple databases and systems to gather information needed to accomplish daily tasks
3. Inputs data accurately into company systems as required
4. Organizes, plans and executes daily departmental tasks in a high volume atmosphere with key focus on accuracy and efficiency
5. Generates accurate and timely billing for customer and vendors; performs other operational accounting duties as required
6. Adheres to department procedures and productivity standards
7. Works effectively in a team setting to accomplish department goals
8. Maintains a positive attitude in a high intensity environment
9. Seeks continuous self-development (R Ex 7)

Petitioner began treating with Dr. Prinz on or about March 30, 2012. (P Ex 1) Dr. Prinz's chart note on that date indicates that Petitioner presents for bilateral hand numbness and right-sided hand pain that *"has been going on now for a couple of years."* He added: *"She feels that they have worsened."* He noted: *"Petitioner has a history of diabetic neuropathy."*

Petitioner continued to work for Respondent until she underwent the right carpal tunnel release on September 5, 2012.

Petitioner testified that when the doctor took the bandages off after the surgery, she noticed that her right ring finger *"didn't go all the way back"* and that she had triggering in her right small finger. Petitioner further testified that she did not have these problems before the right carpal tunnel release. Petitioner testified that post-operatively, Dr. Prinz prescribed physical therapy, splints and a Velcro brace to keep her two fingers together.

On July 17, 2013, Petitioner underwent the left carpal tunnel release, as well as a steroid injection of her right 4th and 5th trigger digits.

Petitioner testified, and the treating records confirm, that she experienced some improvement in her bilateral carpal tunnel sydrome symptoms following such releases.

In his March 12, 2013 chart note, Dr. Prinz wrote the following: "The patient does office work on a computer that is repetitive. I did tell the patient that I do think her work activities are related to her carpal tunnel symptoms." (P Ex 1)

No other physician has specifically offered an opinion as to whether or not Petitioner's bilateral carpal tunnel syndrome - - or the need for carpal tunnel releases - - was causally related to the work activities she performed for Respondent. Dr. Cohen stated that he knew of no "injury" that occurred at work, but such opinion appears to relate to Petitioner's condition post-bilateral carpal tunnel releases.

With respect to the condition of Petitioner's right 4th and 5th fingers injuries, Dr. Prinz opined, on June 24, 2014, as follows:

> *"I told her in my estimation flexor tenosynovitis or trigger digits can develop independently of carpal tunnel syndrome in a diabetic patient. However because of the temporal relationship I do believe that it is possible that she developed trigger digits status post-surgery because of change in the dynamics of flexor tendons. This is not a universally accepted concept ... " (P Ex 1)*

Petitioner has treated with Dr. Prinz since March 30, 2012. The Arbitrator notes that there is no indication in his chart notes of any triggering digits until after the right carpal tunnel release.

Even if one of the medical witnesses were equivocal on the question of causation, it is for the Commission to decide which medical view is to be accepted, and it may attach greater weight to the opinions of the treating physician. International Vermiculite v. Indus. Comm'n, 394 N.E.2d 1166, 77 Ill. 2d (1979)

In this case, the Arbitrator finds the opinions of treating physician Paul T. Prinz, M.D., to be more persuasive than those of the other physicians. Dr. Prinz performed both carpal tunnel release surgeries as well as the injections into Petitioner's trigger digits. Moreover, Dr. Prinz has treated Petitioner regularly from March 30, 2012 through the present.

Based on the foregoing, the Arbitrator finds that on September 4, 2012, Petitioner sustained an accident to her right and left hands that arose out of and in the course of her employment by Respondent and that Petitioner's current conditions of ill-being of her right and left hands, as well as her right 4th and 5th fingers, are causally related to the injury.

In support of his findings and conclusions with regard to issue (K) "Is Petitioner entitled to any prospective medical care?", the Arbitrator finds as follows:

Dr. Prinz has recommended that petitioner undergo surgery in the form of A1 pulley release and possible tenosynovectomy involving the right 3rd, 4th, and 5th fingers.

The Arbitrator has only found Petitioner's right 4th and 5th fingers causally related to the accidental injury of September 4, 2012.

On November 5, 2013, Dr. Prinz was reluctant to perform such surgery. He stated:

> *"Some of this could be from diabetic neuropathy. At this point in time she still has multiple complaints. I am not really convinced that there is anything surgical that I can do to help her. Trigger release in my opinion is a reasonable option but some of her signs and symptoms are somewhat unusual. Exploration of extensor tendons in my estimation may not turn out to be fruitful. I told her that I think the risks of surgery may outweigh*

the benefits but because she is complaining of this issue I think it's wisest to get a second opinion." (P Ex 1)

However, by August 19, 2014, Dr. Prinz changed his opinion. He stated: *"the tenderness at the A1 pulley and symptoms of triggering in my opinion are more likely from tenosynovitis. Therefore with trigger digit release it is possible some symptoms will be improved but I think it unlikely she will regain full active extension at the fourth finger."* (P Ex 1)

The Arbitrator relies on the opinions of Dr. Prinz. The Arbitrator finds the trigger digit releases of the right 4th and 5th fingers to be reasonable, necessary and related to the September 4, 2012 accidental injury.

Therefore, based on the foregoing, the Arbitrator finds that Petitioner is entitled to prospective medical care in the form of trigger digit releases of the right 4th and 5th fingers.

In support of his findings and conclusions with regard to issue (L) "What temporary benefits are in dispute? [TPD]", the Arbitrator finds as follows:

In Arbitrator's Exhibit #1, Petitioner claims 111 weeks (11-30-12 – 7-16-13 and 9-24-13 – 3-26-15) of temporary partial disability benefits (TPD). Respondent disputes such claim. Also, Petitioner claims: "ALL TTD PAID FOR TIME OFF TREATING." Respondent disputes such claim, but asserts that they paid $9,394.75 in TTD benefits and $374.75 in TPD benefits.

Petitioner's testimony with regard to how many hours she currently works per day for Respondent is inconsistent.

Petitioner testified on direct examination that she now works part-time, 4 hours per day.

Yet, she also testified on direct that Dr. Prinz recommended that she cut her hours to 6 hours a day, which she still works today.

Petitioner also testified that between November 30, 2012 and July 16, 2013, Dr. Prinz asked her how she was doing and cut her daily work hours to 6.

However, the documentary evidence indicates that Dr. Prinz's first recommendation that Petitioner cut her daily work hours to 6 was on October 8, 2013. The doctor noted that as of September 24, 2013, Petitioner was working 6 hours a day. Furthermore, Respondent Exhibit #8 shows that Respondent began paying temporary partial disability benefits (TPD) on September 24, 2013.

Respondent's Exhibit #8 shows that Petitioner was paid TPD from September 24, 2013 through November 15, 2013.

The parties have stipulated that Petitioner earned an average weekly wage of $636.00/week. Petitioner worked a 40-hour week prior to the accident. Petitioner was paid a salary with deductions.

The Arbitrator finds that on September 24, 2013, Petitioner began working 30 hours a week (6 hours a day) at the newly imposed hourly rate of $16.79/hour. (P Ex 3) So, her average weekly wage was $16.79 x 30 = $503.70. Then, her TPD rate is $636.00 - $503.70 = $132.30 x 2/3 = $88.20.

The Arbitrator finds that Petitioner is entitled to TPD benefits of $88.20/week for 80-3/7 weeks, from September 24, 2013 through March 26, 2015 (the first hearing date). Respondent is entitled to a credit for TPD benefits previously paid.

After carefully reviewing Respondent's Exhibit #8, Arbitrator's Exhibit #1, and Petitioner's testimony, the Arbitrator concludes that all TTD benefits have been paid. Respondent is entitled to a credit for all TTD benefits previously paid.

In support of his findings and conclusions with regard to issue (M) "Should penalties or fees be imposed upon Respondent?", the Arbitrator finds as follows:

Respondent has paid for Petitioner's bilateral carpal tunnel release surgeries and all other associated medical care. Respondent has also paid TTD benefits, and then some TPD benefits, to Petitioner.

Furthermore, given Petitioner's history of diabetes mellitus and peripheral neuropathy, and given the opinions of Doctors Papierski, Wilson and Cohen, the Arbitrator finds that Respondent had a bona fide dispute with regard to the issue of causal connection between the current condition of ill-being of Petitioner's right 3rd, 4th, and 5th fingers and the injury of September 4, 2012.

Therefore, the Arbitrator finds that penalties and attorney's fees are not warranted in this case.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darrel Reynolds,

Petitioner,

vs. NO. 14 WC015049

Vesuvius USA,

Respondent.

16IWCC0451

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of accident, temporary disability, permanent disability, causal connection, medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 15, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

16IWCC0451

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $49,100.00. 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: JUN 30 2016
SJM/sj
o-6/9/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REYNOLDS, DARREL
Employee/Petitioner

Case# 14WC015049

16IWCC0451

VESUVIUS USA
Employer/Respondent

On 10/15/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1979 LAW OFFICE OF MICHAEL M WOJTAS
PO BOX 1055
ROSCOE, IL 61073

0358 QUINN JOHNSTON HENDERSON ET AL
JOHN F KARMIN
227 N E JEFFERSON ST
PEORIA, IL 61602

16IWCC0451

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

DARREL REYNOLDS
Employee/Petitioner

v.

VESUVIUS USA
Employer/Respondent

Case # 14 WC 15049

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 **August 13, 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? Liability
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **3/4/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**56,056.00**; the average weekly wage was $**1,078.00**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **2** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**5,200.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**5,200.00**.

Respondent is entitled to a credit of $**11,391.30** for medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF **$718.67/WEEK** FOR **12 4/7 WEEKS**, COMMENCING **9/23/2014 THROUGH 11/11/2014** AND **12/19/2014 THROUGH 1/26/2015**. RESPONDENT SHALL BE GIVEN A CREDIT OF $5,200.00.

RESPONDENT SHALL PAY REASONABLE AND NECESSARY MEDICAL SERVICES OF **$4,294.36**, SUBJECT TO THE MEDICAL FEE SCHEDULE AS PROVIDED IN SECTIONS 8(A) AND 8.2 OF THE ACT.

RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF **$646.80/WEEK** FOR A FURTHER PERIOD OF **63.25 WEEKS** AS PROVIDED IN SECTION 8(E)10 OF THE ACT, BECAUSE THE INJURIES SUSTAINED CAUSED **12.5% LOSS OF THE USE OF EACH ARM.**

RESPONDENT SHALL PAY PETITIONER COMPENSATION THAT HAS ACCDRUED FROM MARCH 4, 2014 THROUGH JANUARY 26, 2015, 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

October 11, 2015
Date

OCT 15 2015

DARREL REYNOLDS v. VESUVIUS USA,
14 WC 015049

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter was heard on 8/13/2015 in Illinois, pursuant to an agreement of the parties on the issues of accident, causal connection, TTD, medical (liability) and nature and extent as reflected in the Request for Hearing submitted as Arbitration Exhibit #1. Joe Blake was Respondent's representative at the hearing.

The Arbitrator finds:

A Supervisor's First Report of Accident indicates that on March 4, 2014 Petitioner reported a bilateral elbow strain. With regard to a description of the accident, the Report states that "While employee was using a garden claw to loosen mix in barrel he felt shooting pain starting at elbow down to hand." (PX 1)

Petitioner presented to Lincoln Trail (LT) Occupational Health on March 7, 2014 reporting bilateral elbow pain and requesting an MRI. Petitioner reported working with an auger or claw when the pain became very severe. He acknowledged noticing it many months earlier and added that the pain was worse on the right side with his arms going numb throughout the evening hours. Petitioner was using Aleve to no effect. Petitioner's physical exam was relatively benign with no swelling or bruising and both active and passive range of motion. Petitioner was able to flex and extend against resistance with some facial grimacing and minimal pain. Petitioner was diagnosed with "bilateral pain" and prescribed Motrin for seven days along with ACE bandages at work.

Petitioner returned to LT Occupational Health on March 14, 2014 with ongoing elbow complaints. No treatment changes were made. (PX 2) When Petitioner returned on the 25th of March he underwent bilateral nerve conduction testing. PA-C Steveley noted the "empirical upper limit of normal is 9.6 milliseconds; 12.1 milliseconds." (See also PX 4) An MRI was to be scheduled. Petitioner was to continue with his medications, the ACE bandage as needed, and no restrictions. (PX 2)

The MRI was performed on April 11, 2014. On the right elbow, it revealed findings consistent with ulnar neuropathy and findings suggestive of entrapment within the cubital tunnel and degenerative changes of the elbow joint with severe cartilage loss at the capitellum. The left elbow MRI revealed ulnar nerve entrapment within the cubital tunnel which appeared to be related to an anconeus epitrochlearis muscle and degenerative changes with chondromalacia, severe in the capitellum. (PX 5)

After the MRI Petitioner followed up with PA-C Stevely who noted the left elbow MRI showed ulnar nerve entrapment within the cubital tunnel and the right elbow MRI showed findings consistent with ulnar nerve neuropathy suggestive of cubital tunnel entrapment. No treatment recommendations were made except for the discontinuation of the ACE bandage. PA-C Stevely anticipated surgery but felt Petitioner needed an ortho referral. (PX 2)

Petitioner signed his Application for Adjustment of Claim herein on April 18, 2014. (AX 2)

Petitioner returned to see PA-C Stevely on April 28, 2014 and, while he reported discontinuation of the medications due to concerns about building up a tolerance, Petitioner was encouraged to continue with the none-steroidal anti-inflammatories which would help reduce inflammation within the nerve. Petitioner continued to report that his pain was worse at night and the burning sensation was increasing. Petitioner was diagnosed with bilateral ulnar nerve entrapment and an orthopedic consultation was pending. (PX 2)

PA-C Stevely re-examined Petitioner on May 12, 2014. No changes were made in the treatment plan. Primarily, a discussion was held regarding the status of Petitioner's referral to an orthopedist with Petitioner being advised that workers' compensation was probably sending him for a second opinion. Petitioner was to return in three weeks. (PX 2)

Petitioner underwent a Section 12 examination with Dr. James Williams on May 28, 2014. (RX 2) A written report followed. According to the report Petitioner had worked a variety of jobs over his 17 year career with Respondent. Over the last 8-9 years he had worked as a press filler which required him to take a garden claw and hit it into a mix to break it up. The claw had claws on the end and two handles requiring the use of both hands. Petitioner described how he performed each job he has held. Petitioner told the doctor he began having slight pain from his wrist up to his elbow in the fall of 2013 and just lived with it. He started getting a "shocking" feeling in his elbow around March 4, 2014. Dr. Williams had records from, LT Occupational Health, Midwest Orthpaedic and the First Report of Injury. He also had a copy of the MRIs, nerve conduction study, and functional job analysis. A physical exam was performed with findings noted in the report. It was Dr. Williams' impression that Petitioner had bilateral cubital tunnel syndrome symptoms despite some contraindications based upon his exam. He did not feel Petitioner had undergone adequate non-operative treatment as he felt Petitioner would benefit from an elbow extension splint. He also did not feel Petitioner's symptoms were caused or aggravated by his activities for Respondent. Rather, he felt Petitioner's left-sided complaints were due to his sleeping position and on the right side it was due to his sleeping position and the arthritis at his ulnotrochlear joint and osteophytes. Dr. Williams did not believe Petitioner's job involved any sustained, repetitive, forceful gripping or significant exposure to vibration. He felt Petitioner could continue working full duty and needed no further treatment except for the bilateral elbow extension splints. Dr. Williams noted no evidence of malingering or symptom magnification. (RX 2)

Petitioner next sought medical treatment at the Orthopedic Department at Carle Physicians Group on 7/28/2014 where he saw Kristine Anderson, PA -C. Petitioner gave a history of working for Respondent as a press filler for 17 years having injured himself on March 3, 2014 while using a garden claw to break up a very hard mix. Petitioner described how he had used the claw many times in the past and that the mixture was quite hard; however, on March 3rd he felt a shocking shooting pain from his elbow up and down his arm, with the right side worse than the left. Petitioner described shooting pains with numbness radiating into his entire hand and involving all four digits. Flexion of his elbow also aggravated the pain. Petitioner also reported being placed in some elbow braces at night about two weeks earlier which helped his hand complaints but he remained symptomatic with pain. Petitioner was under no work restrictions. Based upon her physical exam of both upper extremities, Ms. Anderson diagnosed Petitioner with mild symptoms of right medial epicondylitis. She noted the MRI had showed bilateral cubital tunnel syndrome reportedly (she lacked prior tests and records). Ms. Anderson ordered an EMG (PX 6) The EMG was performed on August 19, 2014 and was positive for bilateral cubital tunnel syndrome, as well as mild bilateral carpal tunnel syndrome, without denervation. (PX 7)

Following the EMG, Petitioner was seen by PA-C Anderson and Dr. James Sobeski on 8/27/2014 at which time Dr. Sobeski recommended cubital tunnel releases to both elbows (PX 9). On 9/23/2014, Petitioner underwent a cubital tunnel release with ulnar nerve transposition to the right upper extremity (PX. 13). Dr. Sobeski restricted Petitioner from returning to work from 9/23/2014 through 11/09/2014 (PX 9, 10).

As of November 10, 2014 Petitioner was doing "really well" regarding his right-sided cubital tunnel surgery. The numbness, tingling, and burning pain had resolved and he only mentioned some scar tenderness. He wished to proceed with surgery on the left elbow. (PX 9)

On December 19, 2014 Petitioner underwent a left cubital tunnel release with nerve transposition (PX 18) Dr. Sobeski restricted Petitioner from returning to work from 12/19/2014 through 1/26/2015 (PX 9, 10). There are no further follow-up office notes with Dr. Sobeski.

The parties stipulated that Petitioner received group disability benefits totaling $5, 200.00 while he was restricted from work following the surgeries. He did not receive any TTD benefits.

Petitioner was examined at his attorney's request by Dr. David Fletcher on January 8, 2015. A written report followed. Petitioner was noted to be right hand dominant. He gave a history of developing symptoms beginning on March 4, 2014 which he attributed to the repetitive use of a garden claw while working for Respondent. Petitioner reported having to put a garden claw into a barrel and turning the handles to break up mix in the barrels. On exam Petitioner had atrophy over both hypothenar eminences and bilateral interosseous hand strength. A decreased grip was noted. Dr. Fletcher felt Petitioner needed occupational therapy to build up his strength and endurance. It was Dr. Fletcher's opinion that Petitioner's condition was work-related as it was due to cumulative trauma disorder. He further noted his disagreement with Dr. Williams' causation opinion as Petitioner lacked any other risk factors for the development of his condition. He did not feel Petitioner was at maximum medical improvement and he felt temporary work restrictions were appropriate. As part of his report Dr. Fletcher reviewed all of Petitioner's prior medical records since the alleged accident date as well as a job summary. (PX 26, Ex. 2)

Dr. Fletcher re-examined Petitioner on February 5, 2015. Petitioner descried some tenderness in his elbows but thought it was almost gone. His pain level was "0". Petitioner denied any pain, only tenderness with pressure applied to the bottom of both elbows. Petitioner's Quick Dash rating was noted to be 2.3. Dr. Fletcher felt Petitioner was nearing maximum medical improvement and could return to full duty work as of that date. Dr. Fletcher spent fifteen minutes with Petitioner. (PX 26, Ex. 5)

Dr. Fletcher was deposed on April 28, 2015. Dr. Fletcher is board certified in occupational medicine. He performs independent medical examinations for both petitioners and respondents (45%; 55%) Dr. Fletcher testified consistent with his earlier written report. (PX 26, pp. 10 – 21) He reiterated his opinion that Petitioner's bilateral cubital tunnel syndrome was causally related to his work activities as press filler for Respondent. (PX 26, pages 16-17). Dr. Fletcher also testified that he saw Petitioner again on February 5, 2015 at which time Petitioner reported having undergone therapy and he was very pleased with the improvement in his strength. At that time Dr. Fletcher felt Petitioner could return to unrestricted activity. (PX 26, pp. 20-21)

On cross-examination Dr. Fletcher acknowledged that one can have an idiopathic onset of cubital tunnel syndrome and that heavy alcohol usage could result in someone passing out and striking their elbows. The literature supporting a relationship between alcohol usage and upper extremity complaints is primarily focused on median nerve issues. He also acknowledged that smoking can pose a risk although not a strong risk. Dr. Fletcher didn't believe Petitioner smoked; however, he chewed. Dr. Fletcher also didn't have any information from Petitioner to suggest any correlation/role between outside activities and Petitioner's elbows. He did believe Petitioner engaged in exercise three times a week but it was aerobic in nature, not weight lifting. (PX 26, pp. 21- 24)

Dr. Fletcher further testified that his causation opinion was based upon the accuracy of Petitioner's job description and he had not seen a video of Petitioner's job. He further acknowledged that the Supervisor's Report acknowledged just right-sided pain but Petitioner's problem was bilateral. Dr. Fletcher was also asked about the anconeus epitroclearis noted on the MRI and he explained that it was nothing of significance regarding causation as it is just an extra muscle growing over the ulnar nerve. He acknowledged some people feel it is a condition in and of itself that can cause compression of the ulnar nerve as it is a muscle directly over the nerve. He also agreed that not everyone has it and it actually predisposes one to be more susceptible to stress in that area. He also agreed that degenerative changes in certain structures of the elbow can cause damage or symptoms of compression within the ulnar nerve and that Petitioner had some significant degeneration of his right elbow. He did feel the degeneration in the right elbow was worse than that of the left elbow. He had not actually seen the MRI films, just the reports.

Dr. Fletcher testified that it is the torqueing to Petitioner's elbow stemming from the work activities that is problematic for Petitioner. He also felt, based upon Petitioner's description, that Petitioner had flexion/extension with the job. However, the job description didn't really address/describe the postures. Dr. Fletcher acknowledged that Petitioner has some underlying conditions which made him more susceptible to develop cubital tunnel syndrome. It was also his understanding that Petitioner spent about a third of his day engaged in the torqueing activities and that would meet NIOSH thresholds. (PX 26, pp. 24 – 32)

On redirect examination Dr. Fletcher clarified that the Supervisor's Report referenced both of Petitioner's elbows. (PX 26, p. 32)

Dr. Williams was deposed on May 28, 2015. (RX 1) He is a board certified orthopedic surgeon. Dr. Williams testified consistent with his earlier report adding that the medical treatment, including the surgeries, was reasonable (RX 1, page 48). Dr. Williams also testified that Petitioner's left cubital tunnel syndrome was caused by a muscular anomaly, the right was caused by degenerative changes, and that Petitioner's sleeping posture may be a possible etiology as well (R.E. #3, pages 18-19, 40). He did not believe that Petitioner's job involved any "cumulative" activity that would cause or aggravate cubital tunnel syndrome. He also disagreed that the existence of an extra muscle over the cubital tunnel was simply an irrelevant anatomical variant. In support thereof he acknowledged there are some articles discussing the relationship between cubital tunnel ulnoneuropathy and anconeus epitrochlearis muscles. (RX 2, p. 22) He testified that the muscle itself, regardless of any activity, can in and of its own cause cubital tunnel syndrome.

On cross-examination Dr. Williams acknowledged that the April 13, 2006 job description references that vibratory tools are used to settle the mix, a rake-like device (the claw), a rubber mallet, and an electric

drill. He also admitted that the job description did not contain information regarding the stress needed to use these tools or the torqueing/force used with the tools, or the manner in which the tools were held and used. He, too, did not review a job video. Dr. Williams' understanding of Petitioner's job was based upon what Petitioner told him at the time of their exam. He did not know what type of "mix" Petitioner used the claw to break up. He agreed that Petitioner's history of injury is consistent within the medical records. Dr. Williams acknowledged that Petitioner does not have the anconeus epitrochlearis muscle in the right arm and that the muscle can be a pre-existing factor making one more susceptible to the development of cubital tunnel syndrome. (RX 1, p. 44)

Dr. Williams was asked additional questions about the relationship between Petitioner's sleeping position and his cubital tunnel syndrome. He acknowledged that there would be no force while Petitioner was sleeping and added that cubital tunnel syndrome is not necessarily dependent on a force. He testified:

> [I]t also could be due to just a pressure placed over
>
> the elbow such as one that sits on a chair and keeps
>
> constant pressure over their elbow. It could be caused
>
> by constant flexion of the elbow. (RX 2, p. 46)

When asked to assume that Petitioner continued to be symptomatic even with the splints at night, Dr. Williams still did not feel the sleeping position was merely aggravating Petitioner's condition because it could also mean the condition was so severe that splinting wasn't enough to treat the condition. (RX 2, p. 47) Dr. Williams was under the impression that Petitioner's symptoms in his elbow were worse when he was sleeping. (RX 2,p. 47)

Dr. Williams acknowledged that 90% of his medical/legal work is done for the employer/respondent. He further testified that symptoms at night are a fairly common complaint if one is sleeping with their elbows bent. (RX 2, p. 53)

The Arbitration Hearing

Petitioner testified that he has been employed by Respondent since 1997 and for the last eight years he has been performing the duties of a press filler. Petitioner testified that the job duties of a press filler was accurately described in the written job description (P.E. #27 & 28) but, that in addition to the written description, Petitioner also performed the duties of mixing the compound. Petitioner testified that the mix compound would come in 55 gallon drums and he would have to break up the mix with a garden claw. Petitioner testified that the garden claw was a metal tool approximately chest high. On the far end of the garden claw were four (4) metal prongs and on the top was a key handle. In order to break up the mix compound, Petitioner would drive the garden claw into the mix compound and twist and turn the handle. In order to perform this action, Petitioner would hold the key handle with both hands in front of him and slam it down into the mix compound with enough force to break up the material. Petitioner testified he performed this maneuver 90 to 100 times a day for the last eight (8) years. Respondent's witness, Joe Walker, testimony was not contrary to Petitioner's description.

Petitioner testified that he noticed burning and stinging in his arms on March 4, 2014, told his supervisor, Joe Blake, and completed an Incident Report.

Petitioner testified that on March 4, 2014, Petitioner reported to Mr. Walker that he was experiencing shooting pain starting at his elbows down to the hands while using the garden claw to loosen the mix compound in the barrel (P.E. #1). Petitioner testified that he was sent by his supervisor to Michael Steveley, P.A. at LT Occupational Health. The history given to Mr. Steveley by Petitioner was that he was experiencing pain to both elbows while using a claw or auger over many months but, that it became severe on 3/4/2014 (P.E. #2, page 4).

Petitioner testified that he has been working his regular job (press filler) since returning to work on January 26, 2015. Petitioner denied any problems with his elbows before going to work for Respondent. He has noticed a loss of strength in that he can't push or pull without it hurting. The pre-surgical pain is gone but he still has some pain but it's "different."

Petitioner's medical bills were paid by his group insurance. He also paid $500.00 out-of-pocket for each surgery.

Petitioner admitted that when he first sought medical treatment with Occupational Health he noted he had noticed symptoms many months ago and that his pain was worse on the right side and that they would go to sleep in the evening hours.

An employee training package was admitted into evidence as PX 27. It included a Physical Demands Analysis form for a Press #1 Filler, including the amount of time during the work day spent standing, walking, sitting, lifting, and carrying. No information was provided regarding the amount of pushing or pulling. The job was described as having a combined strength of "heavy." Job tasks included lifting funnels, lifting bags (molds), lifting buckets of mix, lifting closures, lifting head and ears, lifting a vacuum, and lifting a "PUR." Other physical demands were listed on pages 3 through 6. (PX 27) A Functional Job Analysis was admitted as PX 28.

Petitioner's medical bills included:

LT Occupational Health -- $73.00 balance (PX 3)

Carle Foundation Hospital -- $0 balance (PX 8)

Carle Physician Group -- $0 balance (PX 11)

Carle Foundation Hospital -- $205.00 balance (PX 12)

Carle Foundation Hospital -- $11.70 balance (PX 14)

Carle Foundation Hospital -- $640.71 balance (PX 15)

Carle Foundation Hospital -- $205.00 balance (PX 17)

Hoopeston Regional Health Center - $290.00 balance (PX 19)

Carle Foundation Hospital -- $648.52 balance (PX 20)

Sarah Bush Lincoln -- $675.43 balance (PX 22)

Sarah Bush Lincoln -- $320.00 balance (PX 24)

Carle Foundation Hospital -- $225.00 balance (PX 25)

Altogether the outstanding medical bills total $3, 294.36.

The Arbitrator concludes:

Issues (C) Accident and (F) Causal Connection.

Petitioner sustained an accident on March 4, 2014 that arose out of and in the course of his employment with Respondent. He further proved that his current condition of ill-being in his elbows is causally connected to his accident of March 4, 2014.

For the last eight (8) years Petitioner has been performing the duties of a press filler, and his job required him to break up the mix compound with a garden claw, using both arms/hands on the handles, 90 to 100 times per day with a downward driving motion which placed a significant amount of force to both elbows which resulted in the gradual development of his bilateral cubital tunnel syndrome manifesting itself on 3/4/2014.

The Arbitrator finds the testimony of Petitioner credible. Respondent's witness's testimony was not contrary to that of Petitioner. The Arbitrator also found the medical histories of LT Occupational Health and Carle Physicians Group consistent with Petitioner's testimony.

On the issue of whether Petitioner's condition of ill-being is causally connected to the work accident, the Arbitrator finds Dr. Fletcher's testimony more persuasive than that of Dr. Williams. Dr. Fletcher was aware of Petitioner's work activities and provided an opinion that Petitioner's bilateral cubital tunnel syndrome was caused by Petitioner's work activities. The Arbitrator did not find Dr. William's testimony persuasive. The doctor made enough concessions during cross-examination to undermine his opinion regarding the role of Petitioner's sleep position and its relationship to Petitioner's upper extremity condition. The doctor acknowledged on cross-examination that Petitioner's condition could have been severe enough already that the sleeping position would be irrelevant. Petitioner's anatomical/pre-existing condition of his elbows may, as the doctors acknowledged, have made him more susceptible to the effects of his job duties. Based on the above, the Arbitrator finds a causal connection between Petitioner's bilateral cubital tunnel syndrome and the March 4, 2014 accident.

Issue (J) Medical Bills.

On the issue of medical bills, the Arbitrator notes Respondent's dispute was based solely on liability. As the Arbitrator has found the issues of accident and causal connection in favor of Petitioner she finds the treatment to be reasonable and necessary. It is ordered that Respondent pay all outstanding medical bills submitted by Petitioner into evidence:

LT Occupational Health -- $73.00 balance (PX 3)

Carle Foundation Hospital -- $0 balance (PX 8)

Carle Physician Group -- $0 balance (PX 11)

Carle Foundation Hospital -- $205.00 balance (PX 12)

Carle Foundation Hospital -- $11.70 balance (PX 14)

Carle Foundation Hospital -- $640.71 balance (PX 15)

Carle Foundation Hospital -- $205.00 balance (PX 17)

Hoopeston Regional Health Center - $290.00 balance (PX 19)

Carle Foundation Hospital -- $648.52 balance (PX 20)

Sarah Bush Lincoln -- $675.43 balance (PX 22)

Sarah Bush Lincoln -- $320.00 balance (PX 24)

Carle Foundation Hospital -- $225.00 balance (PX 25)

Altogether the outstanding medical bills total $3, 294.36. The award of medical bills is subject to the Medical Fee Schedule. In addition Respondent shall reimburse Petitioner the sum of $1,000.00 for his two $500.00 co-pays incurred with regard to his surgeries. Petitioner submitted one bill detailing the co-pay and his testimony regarding there being two co-pays was unrebutted. The total amount of the medical awarded is $4,294.36.

Issue (K) Temporary Total Disability Benefits.

Respondent did not dispute the dates of temporary total disability, only liability for them. Consistent with her liability determination, Petitioner is awarded temporary total disability benefits from 9/23/2014 through 11/11/2014 and 12/19/2014 through 1/26/2014 for a total period of 12 4/7 weeks.

Issue (L) Nature and Extent.

On the issue of nature and extent, the Arbitrator finds the claim is subject to Section 8.1(b) of the Illinois Workers' Compensation Act, and in accordance with Section 8.1(b), the Arbitrator has considered the following factors when rendering her decision regarding the issue of permanency:

i. **The reported level of impairment pursuant to subsection (a):**
No impairment rating was performed and no impairment rating report was submitted into evidence. The Arbitrator gives this factor no weight.

ii. **The occupation of the injured employee:**
Petitioner was employed as a press filler at the time of the accident. Following the treatment for his condition, Petitioner was able to continue to work for Respondent in the same position. The evidence presented shows Petitioner's job to be manual in nature and requires Petitioner to lift and move medium to heavy material. The Arbitrator gives this factor some weight.

iii. **The age of the employer at the time of the injury:**
Petitioner was 45 years old when he underwent medical treatment for the bilateral cubital tunnel syndrome. Due to Petitioner's young age, the Arbitrator finds it reasonable to infer that Petitioner's disability may have a greater impact than that of an older worker because he will

have to work with the injury for a longer time period. The Arbitrator gives this factor some weight.

iv. **The employee's future earning capacity:**
Petitioner was able to return to his regular job for Respondent. There was no evidence to show a loss of earning capacity. The Arbitrator gives this factor no weight.

v. **Evidence of disability corroborated by treating records:**
Petitioner sustained injuries to both elbows, for which Dr. Sobeski preformed a right cubital tunnel release with ulnar nerve transposition on 9/23/2014 and a left cubital tunnel release with ulnar nerve transposition on 12/19/2014. Petitioner testified he continues to experience some pain and soreness to his elbows. When his right elbow was last examined by Dr. Sobeski, Petitioner was doing very well with his only complaint being some tenderness in the area of the incision. There is no follow-up visit with Dr. Sobeski after the left-sided surgery. Petitioner testified to loss of strength as a result of his surgery but Dr. Sobeski's records don't corroborate this. Dr. Fletcher was not a treating physician. Thus, the treating records don't really corroborate Petitioner's testimony and the Arbitrator gives this some weight in determining disability.

Taking into account the aforementioned factors, the Arbitrator concludes that Petitioner sustained injuries resulting in permanent disability of 12.5% loss of use of each arm as provided by Section 8(e)10 of the Act.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shetrice Baker,

Petitioner,

vs. NO. 10WC038527

Oak Park School District #97,

Respondent.

16IWCC0452

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of accident, temporary disability, permanent disability, causal connection, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 28, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

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: JUN 30 2016
SJM/sj
o-5/19/16
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BAKER, SHETRICE Y
Employee/Petitioner

Case# **10WC038527**

16IWCC0452

OAK PARK SCHOOL DISTRICT #97
Employer/Respondent

On 9/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1994 LAW OFFICE OF DONALD GALLAGHER
200 W BURLINGTON
PO BOX 13
CLAREDON HILLS, IL 60514

0863 ANCEL GLINK
TIFFANY NELSON-JAWORSKI
140 S DEARBORN ST SUITE 600
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

16IWCC0452

☐ 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

Shetrice Y. Baker
Employee/Petitioner

v.

Oak Park School District #97
Employer/Respondent

Case # **10** WC **38527**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Molly C. Mason, Arbitrator of the Commission, in the city of **Chicago**, on **August 27, 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 _____

16IWCC0452

FINDINGS

On **05/21/10**, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain injuries secondary to repetitive trauma arising 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, the Petitioner earned **$26,520.00**; the average weekly wage was **$510.00**.

On the date of accident, Petitioner was **42** years of age, ***married*** with 0 children under 18.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services. Respondent is entitled to Section 8(j) credit for the $7,963.00 in medical expenses paid by the group carrier (Arb Exh 1) and shall hold Petitioner harmless against any claims made by said carrier.

ORDER

Respondent shall pay Petitioner the sum of **$306.00** per week for 51.25 weeks for her disability as provided under Section 8(e) of the Act, because the injuries sustained caused 12.5% loss of use of each of Petitioner's hands.

Respondent shall pay Petitioner compensation that has accrued from 09/21/11, 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.

Molly C Mason
Signature of Arbitrator

September 25, 2015
Date

AM 54888625.1

SEP 28 2015

Shetrice Y. Baker v. Oak Park School District #97
10 WC 38527

16IWCC0452

Arbitrator's Findings of Fact

Petitioner testified she began working for Respondent in 1997. During her first four years of employment, she supervised children at an elementary school. Initially, her daily tasks included cleaning tables, washing, drying and stacking trays and assisting the manager with typing payment-related information into a computer. She then became head cook. In August of 2001, she began working as a cafeteria manager at a middle school. She worked from 7:45 AM to 2:00 PM each school day. She never worked in the summers.

Petitioner testified her cafeteria managerial duties have remained essentially the same since 2001.

Petitioner testified that about 50 children ate breakfast at the school cafeteria each day. Petitioner testified she worked alone throughout the breakfast shift. Before the children arrived, she set up the bins of cereal and other items. After they arrived, she had to key each child's name into the computer. After breakfast came to an end, she cleaned up the cafeteria and prepared for lunch by setting up the cooler, putting condiments in containers, unloading hot meals from "CAMBRO" containers, setting the hot meals out on tables and carrying crates of small milk cartons. Each crate contained 50 4-ounce containers of milk. About 300 children ate lunch every day, except on "pizza day," when 400 children partook. After the children arrived, at about 11:15 AM, she had to check each child in. If the child had an ID available, she used a hand-held scanner to scan the bar code on the ID. If the child had forgotten to bring his ID, she had to key his name into the computer. Lunch lasted until about 1:30 PM. After lunch, she had to carry the somewhat depleted milk crates back and key each milk order into the computer. On "pizza day," as many as 120 children ordered milk.

Petitioner testified she first began experiencing pain in her hands, arms and shoulders in January 2010. The pain was worse on the right. She is right-handed. The pain affected her sleep. She denied having any problems with her hands or wrists before this.

Petitioner testified she continued performing her usual duties after January 2010. She tried applying hot and cold compresses to her affected body parts but this did not help.

On May 7, 2010, Petitioner saw her family physician, Dr. Clanton. Dr. Clanton had treated her in the past, when she underwent "lap band" surgery. Petitioner testified that, on May 7, 2010, she told Dr. Clanton her hands were hurting and "giving out." He recommended she undergo an EMG.

Dr. Clanton's handwritten note of May 7, 2010 is difficult to read but it appears to state: "c/o numbness hands work." Another handwritten note on the same page documents complaints of pain in the right arm and hand and numbness on the right side.

Petitioner underwent the recommended EMG on May 12, 2010. Dr. Shah performed the EMG. He described Petitioner as a right-handed cafeteria manager. He noted a history of pain in both forearms and numbness in both hands, right greater than left, since December 2009. He also noted a history of "lap band" surgery in 2009. He described Petitioner's history as negative for diabetes.

On examination, Dr. Shah noted a normal range of motion and negative Tinel's and Phalen's. In one paragraph of his report, he described the EMG as "essentially within normal limits." In his concluding paragraph, however, he described the findings as "suggestive of bilateral carpal tunnel syndrome, right greater than left." He recommended follow-up care, splinting and thyroid function testing. PX 4.

Petitioner identified PX 2 as an Employee's Report of Injury she completed on May 21, 2010. In this report, she indicated her problems progressed from finger to hand to arm pain over time. She also indicated she learned she had carpal tunnel on May 19, 2010, after undergoing an EMG. [Notice is not in dispute.]

Petitioner also offered into evidence an Illinois Form 45/Employer's First Report of Injury completed by a nurse on May 21, 2010. The report reflects that Petitioner began experiencing numbness and tingling of both hands and wrists over the preceding year. The nurse indicated that these symptoms stemmed from Petitioner's daily responsibilities, including "typing, lifting boxes, lifting trays and writing." She indicated Petitioner had undergone an EMG. PX 1.

Petitioner returned to Dr. Clanton on June 18, 2010. The doctor noted the EMG results along with a complaint of bilateral wrist pain. The rest of the note is difficult to read.

Petitioner testified that, on June 18, 2010, Dr. Clanton prescribed wrist splints and referred her to Dr. Heller. Petitioner testified she thereafter began wearing the splints except when bathing or sleeping. She did not derive relief from the splints.

At Respondent's request, Petitioner saw Dr. Vender for a Section 12 examination on August 18, 2010. In his report of August 20, 2010 (Vender Dep Exh 2), the doctor noted complaints of pain in both wrists and numbness in both hands (involving the middle and ring fingers) since December 2009 or January 2010. He also noted that Petitioner remained symptomatic despite using splints and that her right-sided pain was more diffuse. He described Petitioner as 5 feet, 3 inches tall and weighing 240 pounds.

After examining Petitioner, reviewing records and obtaining bilateral wrist X-rays, Dr. Vender diagnosed "possible bilateral carpal tunnel syndrome." He indicated that the EMG report he had received was marked as "preliminary," with the examiner interpreting the results as "suggestive" of bilateral carpal tunnel syndrome. Dr. Vender expressed a desire to "review

the full study." He indicated that if the full study proved reliable, "the diagnosis of bilateral carpal tunnel syndrome would then be more certain."

With respect to causation, Dr. Vender commented as follows:

> "In looking for a contribution of work activities to the development of carpal tunnel syndrome, one would look for forceful and exertional activities performed on a regular and persistent basis through the workday. If Ms. Baker's activities as a cafeteria manager have persistent forceful use, this may be contributory to her condition. Ms. Baker also has a medical risk factor for the development of carpal tunnel syndrome in the way of her increased body mass index."

Vender Dep Exh 2.

Petitioner first saw Dr. Heller on October 12, 2010. Petitioner completed a history form on that date indicating she attributed her hand, wrist, arm and shoulder pain to work. She specifically mentioned "typing in" about 400 children's names per day and cleaning tables. On a separate form, she indicated that, when swiping an ID, she had to "flick [her] wrist and squeeze."

In his initial note, Dr. Heller described Petitioner as a 42-year-old, right-handed cafeteria worker "complaining of bilateral hand burning and tingling as well as arm and shoulder pain" for more than six months. On examination, Dr. Heller noted a normal range of shoulder, elbow and wrist motion, no triggering or locking of the fingers, no evidence of tenosynovitis or thenar atrophy, no carpal instability and mildly positive median nerve compression testing bilaterally, right slightly worse than left. He noted that electrodiagnostic studies performed in May 2010 showed bilateral carpal tunnel syndrome. He diagnosed "mild bilateral carpal tunnel syndrome and generalized arm pain." He performed a right carpal tunnel injection and advised Petitioner to return in a week for a possible left-sided injection. PX 4.

Petitioner returned to Dr. Heller on October 19, 2010 and reported no real relief from the injection. Dr. Heller noted that Petitioner continued to complain of arm and shoulder pain. He prescribed Toradol and therapy. He directed Petitioner to follow up with him if her symptoms localized towards her hands and fingers. PX 4.

On October 21, 2010, Dr. Vender issued a letter indicating he had reviewed the EMG report of May 12, 2010. Dr. Vender stated he did not find the data provided in this report to be "reliably indicative of carpal tunnel syndrome." He recommended that Petitioner undergo a repeat EMG before reaching a diagnosis or addressing treatment needs. Dr. Vender also indicated he reviewed a "lunch room manager" job description and did not see information

provided therein that would indicate the type of activities that would be considered contributory to the development of bilateral carpal tunnel syndrome." Vender Dep Exh 3.

Petitioner underwent occupational therapy between early November and early December 2010. Petitioner discontinued therapy on December 7, 2010 due to lack of improvement. The therapist noted Petitioner was continuing to perform home exercises and wear splints. PX 4.

Petitioner returned to Dr. Heller on January 25, 2011. She reported some improvement in her right wrist but indicated she still experienced swelling and pain in the wrist on waking. She also indicated she had completed therapy.

On examination, Dr. Heller noted no abnormalities. He recommended splinting and prescribed Naprosyn. He directed Petitioner to follow up with him as needed. PX 4.

Petitioner next saw Dr. Heller on June 7, 2011. The doctor noted a complaint of waking at night due to burning and tingling in the right hand. He discussed the possibility of a right-sided release and noted Petitioner planned to discuss this with her spouse. PX 4.

Dr. Heller performed a right carpal tunnel release on July 20, 2011. PX 4. At the first post-operative visit, on August 5, 2011, he noted that Petitioner reported complete relief of her symptoms and wanted to schedule a left-sided release. PX 4.

Dr. Heller performed a left carpal tunnel release on September 7, 2011. On September 23, 2011, he noted that Petitioner described her right hand as "symptom free." He removed the sutures from the left wrist and indicated Petitioner did not need therapy. He noted that Petitioner already had the appropriate splints to use while driving and planned to return to light duty the next day. He imposed a restriction of no heavy lifting with the left hand. PX 4.

Petitioner testified she did not return to Dr. Heller thereafter. She resumed working but performed her regular job duties because Respondent did not provide work within her restriction.

On January 29, 2013, Petitioner underwent an examination by Dr. Coe at her attorney's request. In his report of the same date, Dr. Coe noted that Petitioner told him about 300 to 400 meals were served per day in the cafeteria where she works. Dr. Coe also noted that Petitioner's duties included lifting, carrying, stocking such items as milk crates and performing "repetitive computer keyboard data entry," including entry of stocked/ordered items and student names and ID numbers. According to Dr. Coe, Petitioner reported performing data entry up to 150 times per day.

Dr. Coe indicated he reviewed the EMG report along with records from Drs. Clanton and Heller and Dr. Vender's report of August 2010. He also indicated that Petitioner denied any significant hand or arm injuries prior to performing her stated duties at Respondent in

December 2009. He further stated that Petitioner denied any hand-intensive home activities. He noted that Petitioner denied smoking and denied any history of diabetes, thyroid disease, collagen disease or vascular disease.

Dr. Coe noted that, in his right carpal tunnel release operative report, Dr. Heller documented compression of the median nerve under the transverse carpal ligament. He further noted that, in the operative report concerning the left-sided release, Dr. Heller "described left median nerve compression."

Dr. Coe indicated that Petitioner reported resolution of her pre-operative pain and tingling following the carpal tunnel surgeries but still complained of her post-operative scarring as well as left hand numbness.

Dr. Coe described Petitioner as 5 feet, 3 inches tall and weighing 232 pounds. He noted she is right-handed. On bilateral hand examination, he noted 1-inch, well-healed scars on both palms, decreased sensation over the left palm scar, no pillar tenderness, a normal range of motion in both wrists, negative Phalen's and Tinel's signs bilaterally and grossly intact sensation. He measured pinch grip strength at 18 pounds on the right and 16 pounds on the left.

Dr. Coe indicated he reviewed the same job description that Dr. Vender reviewed. He stated that, while the job description referenced use of computers, filing, reaching and occasional lifting of up to 25 pounds, it did not contain more detailed ergonomic information.

Dr. Coe opined that the repetitive work Petitioner performed as a cafeteria manager resulted in repetitive strain injuries to both upper extremities. In his view, these injuries "were a factor causing the development of bilateral carpal tunnel syndrome. He further opined that the repetitive strain injuries caused permanent partial disability to both hands. PX 5.

On October 31, 2013, Dr. Vender issued another supplemental report after reviewing a September 23, 2013 job analysis report, Dr. Coe's report, Dr. Heller's records and a video labeled "Oak Park SD Shetrice Baker 9/20/13." Dr. Vender described the video as showing a worker wheeling a cart that held a pan of food, placing the cart onto a counter, working in an office setting, moving other equipment via a cart and handling electrical cords. The Arbitrator also viewed this video. RX C.

In response to a causation-related question, Dr. Vender commented that none of the information he reviewed prompted him to change the causation-related opinions he previously expressed. He described the work activities as neither forceful nor repetitive and not contributory to the development of carpal tunnel syndrome. In response to a question concerning the reasonableness and necessity of care, Dr. Vender indicated that, as far as he could tell, Petitioner did not undergo the repeat EMG he previously recommended. While surgery might not have been his choice of treatment, he could not say that the treatment provided was below the standard of care. Vender Dep Exh 4.

Dr. Vender testified by way of evidence deposition on May 30, 2014. RX A.

Dr. Vender testified he is board certified in orthopedic surgery and has additional qualification in hand surgery. He underwent fellowship training in hand surgery. RX A at 5. Vender Dep Exh 1.

Dr. Vender testified he devotes less than 10% of his practice to examinations and depositions. RX A at 6. He examined Petitioner once, on August 18, 2010, and issued several reports. He has no independent recollection of the reports. RX A at 7.

Dr. Vender testified that, as of his examination, Petitioner complained of pain in both wrists and numbness in both hands. Petitioner denied any night symptoms. Such symptoms are "classic" signs of carpal tunnel syndrome. RX A at 8-9. He obtained X-rays, which showed slight widening of the scapholunate intervals, but he felt this "most likely represented a variant of normal" in Petitioner's case. RX A at 10. Based on his findings, he felt it was possible Petitioner had bilateral carpal tunnel syndrome. He could not confirm this absent electrodiagnostic studies, which had not been provided to him. He received only a preliminary report which stated that the results were "suggestive" of carpal tunnel syndrome. RX A at 10. Based on this, he "could not make a reliable diagnosis." RX A at 11. He felt Petitioner could continue full duty because carpal tunnel syndrome is "not a condition that requires restrictions." Rather, it is a "condition of inconvenience," meaning the person who has it experiences intermittent numbness and tingling. "When that occurs, you stop briefly and the numbness goes away." RX A at 11. Moreover, it did not appear that Petitioner's cafeteria-related job would be overly demanding of her hands. RX A at 11-12. In his opinion, a typical cafeteria worker would not need to perform forceful, exertional activities. RX A at 12-13. His causation opinion could change because he remains "open" to learning more about Petitioner's specific duties. RX A at 13. Petitioner, at 5 feet, 3 inches tall and 240 pounds, is obese. Obesity is a major risk factor for carpal tunnel syndrome. RX A at 13.

Dr. Vender identified Dep Exh 3 as the addendum he prepared on October 21, 2010, after reviewing the EMG, which was again "suggestive of" carpal tunnel, and a formal job description. He saw no activities listed in the job description would be repetitive or significantly forceful. RX A at 15. He remains unsure whether Petitioner in fact has carpal tunnel. Assuming she has it, the EMG and job description did not prompt him to change his causation opinion. RX A at 15-16.

Dr. Vender identified Dep Exh 4 as another addendum he issued on October 31, 2013, after he reviewed the same EMG, Dr. Coe's report, records from Midland Orthopedics and Mercy Hospital and video footage obtained on September 20, 2013. RX A at 17. He is not sure whether the worker shown in the video is Petitioner. The activities shown in the video, i.e., pushing a cart, placing a pan of food on a counter and handling electrical cords in an office setting, would not contribute to the development of carpal tunnel syndrome. RX A at 17-18.

Dr. Vender testified he does not agree with Dr. Coe's causation-related opinions. The work activities Dr. Coe cited in his report primarily involved the serving of food. This activity is "not at all forceful." RX A at 19. Even if Petitioner served food all day, there is nothing particularly forceful about it. RX A at 20. If a worker's activities vary, he or she has less of a chance of developing carpal tunnel syndrome. RX A at 20.

The surgery Petitioner underwent would not be related to her work. He would not have operated on her because he does not operate on a person who lacks a reliable electrodiagnostic study. Obviously, however, that would be "her treating doctor's judgment." RX A at 21.

Under cross-examination, Dr. Vender testified he saw Petitioner once. Of the examinations he performs, 90% are for employers. RX A at 22-23.

Dr. Vender testified that half of the cases of carpal tunnel syndrome have no underlying cause. RX A at 24. Various factors contribute to the remaining half. The most important of those are obesity, smoking, diabetes and hypothyroidism. Work activities are a potential risk factor under certain circumstances. RX A at 24. Repetition alone is not a risk factor. The repetitiveness has to be combined with force. RX A at 25. Scanning items with a wand is a low risk activity, as is typing. If he is unable to interpret an EMG on his own, he would have the EMG repeated before operating on a patient. RX A at 27. He would not recommend splints before surgery if the patient had no symptoms and he suspected carpal tunnel syndrome. RX A at 28. Trauma is a very limited factor in the development of carpal tunnel syndrome. People break their wrists all the time and do not develop carpal tunnel syndrome. RX A at 29. It is difficult to assign a percentage to the major risk factors, such as obesity. RX A at 30. He is neutral as to whether Petitioner required surgery because he "never really had the evidence" that Petitioner has carpal tunnel syndrome. RX A at 31. He never had a chance to speak with the worker depicted in the video. RX A at 31.

On redirect, Dr. Vender testified that half of the IMEs he performs are in undisputed claims, for treatment purposes. RX A at 32. He devotes 90% of his entire practice to treating his own patients. He occasionally testifies as a treater. RX A at 32. He will write a causation-related letter on behalf of a patient if he believes the patient's condition stems from work. RX A at 32-33.

Dr. Coe testified by way of evidence deposition on April 17, 2015. Dr. Coe testified he obtained his Illinois medical license in 1974. He obtained board certification in occupational medicine in 1991. PX 6 at 5-6.

Dr. Coe testified he has some independent recollection of Petitioner because of the nature of her occupation. PX 6 at 7. He saw Petitioner once, on January 29, 2013. PX 6 at 8. Petitioner described the tasks she performs as a cafeteria manager. She denied having any hand or wrist symptoms before she performed these tasks. PX 6 at 11. She also denied any history of smoking and any history of systemic diseases such as diabetes and hypothyroidism.

PX 6 at 12. She told him she does not have any hand-intensive hobbies such as knitting or crocheting. PX 6 at 12.

Dr. Coe testified as to the various records and reports he reviewed. He opined that Petitioner's reported pre-operative symptoms are common in people with clinically significant carpal tunnel syndrome. PX 6 at 14-15. He also noted that Dr. Heller documented observing compression of the median nerve in his right carpal release operative report. PX 6 at 16. Petitioner told him she still had some numbness, particularly in her left hand, postoperatively but that the surgeries relieved her pain and sense of weakness. PX 6 at 18. By the time he examined her, her operative scars were well-healed but she had decreased sensation over the left-sided scar. PX 6 at 19. Petitioner's other examination findings, including the negative Phalen's and Tinel's, were consistent with a successful surgical outcome. PX 6 at 19. The pinch grip measurements showed "moderate preservation of pinch grip strength." PX 6 at 19. His principal examination findings were "post-operative scars and the sensory change surrounding the left palm scar." PX 6 at 20.

Dr. Coe testified he diagnosed bilateral carpal tunnel syndrome, for which Petitioner was status post surgery, based on Petitioner's history, description of her job duties and the records. He did not view Petitioner as requiring any additional care. PX 6 at 20-21.

Dr. Coe opined, to a reasonable degree of medical certainty, that there is a causal relationship between Petitioner's work duties and the development of her bilateral carpal tunnel syndrome. He based this opinion, in part, on Petitioner's description of using her hands in a repetitive and forceful way in serving, stocking, performing data entry, entering students' numbers and names, writing and lifting boxes. This description, combined with the lack of other significant risk factors, prompted him to form this opinion. PX 6 at 22.

Dr. Coe further opined that the treatment Petitioner underwent was reasonable and necessitated by the diagnosis of carpal tunnel syndrome. The treatment was also ultimately successful. PX 6 at 23. Petitioner's subjective complaints were consistent with his findings and his records review. PX 6 at 23. Petitioner did not require more treatment. PX 6 at 24.

Under cross-examination, Dr. Coe acknowledged discussing the claim with Petitioner's counsel before the deposition. The discussion consisted of him asking counsel whether Petitioner had undergone additional care. PX 6 at 24-25. Counsel did not provide him with any additional records. PX 6 at 25. Counsel has referred a couple of cases to him in the past. PX 6 at 25.

Dr. Coe acknowledged he is not a surgeon. PX 6 at 25. About 10% of his practice involves hand or wrist injuries of one type of another. PX 6 at 25.

Dr. Coe acknowledged that Petitioner's body mass index was 41 at the time of his examination and that this places Petitioner in the obese category. It is debatable whether obesity is a risk factor for carpal tunnel syndrome. He agrees there is a possibility of this. PX 6

at 26. Dr. Shah's comment, i.e., that Petitioner's EMG is "suggestive" of carpal tunnel syndrome is consistent with his being a neurologist. Neurologists frequently write reports in this fashion. Carpal tunnel syndrome is just that, a syndrome. In medicine, the term "syndrome" refers to a "group of symptoms that tend to occur at the same time." You can reach the diagnosis via clinical examination, diagnostic testing or surgery. PX 6 at 27. Likely, Dr. Shah was saying that Petitioner's EMG was consistent with the diagnosis but he could not rule out other conditions. In Petitioner's case, "ultimately it was clear that what she had was true carpal tunnel syndrome." PX 6 at 28.

Dr. Coe testified that Petitioner told him about her job duties and that he reviewed a "very basic" job description. He did not visit the cafeteria where Petitioner works. Nor did he view any job videos. PX 6 at 29. Petitioner provided more detail than the written job description. PX 6 at 29. It is reasonable to conclude that Petitioner performed a variety of tasks. PX 6 at 30. Petitioner indicated that the tasks required forceful and repetitive work of her upper extremities but it is "hard to tell" which tasks required this. He asked Petitioner about the force required of her but she could not provide him with detailed information. PX 6 at 30.

On redirect, Dr. Coe testified he reviewed Dr. Vender's August 20, 2010 report. Dr. Vender prepared this report before the surgeries took place. PX 6 at 31. His review of Dr. Vender's report did not prompt to change his opinion that Petitioner's carpal tunnel syndrome was caused or aggravated by her work accident. PX 6 at 32.

Petitioner testified she continues to work as a cafeteria manager for Respondent. The surgeries helped in the sense that they reduced her hand pain but she still experiences hand fatigue when writing and weakness when carrying milk crates. As far as she knows, Blue Cross Blue Shield covered her medical bills.

Under cross-examination, Petitioner testified she works alone at breakfast. She typically carries one milk crate at a time. At lunch, three co-workers help with serving food while she types and keys names. When she encounters a common name, such as Jones, she only has to key in a few letters before the entire name appears. With less common names, she has to key in more or all of the letters. She does not recall telling Dr. Vender she did not experience symptoms at night. She has had night pain since the beginning. Dr. Vender recommended she undergo surgery. If he testified otherwise, she would dispute that testimony. Jacky Ormsby came to the school on September 23, 2013 and filmed her. Trays are the heaviest items she carries. Ormsby weighed one of these trays. The tray weighed 25 pounds. RX D, a written description of her job, is accurate. She believes she underwent "lap band" surgery before being diagnosed with carpal tunnel syndrome. She performs a variety of duties. When Respondent is short-staffed, she has to fill in. Keying is the activity she performs most frequently at work. The touching she performs when "wanding" student IDs is forceful. She has to use force to get the wand to trigger. The level of force is akin to squeezing an orange. Before she underwent surgery, the activity of wanding was very painful. She does not know what Dr. Coe's specialty is. She returned to work despite the fact that her restriction was not accommodated because

she "couldn't not do [her] job." However, she tried to avoid lifting heavy items when possible. She only underwent one EMG. Dr. Vender wanted her to undergo another EMG but this was not authorized.

On redirect, Petitioner testified she has seen airport employees use wands. The device she used was not like those wands. It was a scanner. She spent most of each workday scanning and inputting data. This is referenced in her job description. [RX B contains a copy of a photograph showing Petitioner holding the scanner but it does not contain any photographs showing Petitioner performing scanning.]

Under re-cross, Petitioner acknowledged giving a statement on June 4, 2010. She does not recall being told that the statement was being recorded. After looking at a transcript of the statement (RX E), she acknowledged it accurately states she performed a variety of tasks.

No other witnesses testified at the hearing.

Arbitrator's Credibility Assessment

Petitioner's testimony concerning her job duties was detailed and corroborated by her treatment records. The Arbitrator notes that the scanning activity that Petitioner described as most taxing, in terms of causing hand fatigue, is not shown on Respondent's job video.

Did Petitioner sustain an accidental injury secondary to repetitive trauma? Did Petitioner establish a causal connection between that injury and her current bilateral hand condition of ill-being?

The Arbitrator finds that Petitioner established a compensable injury secondary to repetitive trauma. The Arbitrator further finds that Petitioner established a causal relationship between that injury and the need for surgery as well as between that injury and her current post-operative bilateral hand/wrist condition of ill-being. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any hand problems prior to January 2010; 2) Petitioner's credible testimony concerning the scanning/data entry and other tasks she performed each day; 3) the written job description (RX D), which reflects that Petitioner was "regularly required" to "use hands to finger, handle or feel" and that she was "responsible for the fiscal integrity of the building program." The job description makes it clear that it was up to Petitioner to verify that only eligible students received meals. Petitioner verified this information by scanning bar codes on student IDs and inputting the last names of students who had forgotten to bring their IDs to school. Petitioner credibly testified she regularly dealt with large groups of children, particularly at lunch, and was required to work quickly. She also credibly testified she had to apply force with her hands to get the scanner to trigger.

The Arbitrator also notes that Petitioner's symptoms arose during the school year as opposed to during the summer, when she was off work. Finally, the Arbitrator notes there is no evidence that Petitioner suffers from diabetes or a thyroid disorder. While there is evidence

of obesity, with Dr. Vender describing this condition as a cause of carpal tunnel, a claimant in Illinois need only establish that work was a cause of his condition. He need not eliminate all other possible contributing causes. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003).

The Arbitrator does not find Respondent's examiner, Dr. Vender, persuasive. On several occasions, Dr. Vender recommended that Petitioner undergo repeat EMG studies to confirm the diagnosis of carpal tunnel syndrome. No such studies were performed. Dr. Vender based his causation opinion in part on a job video that did not show the scanning activity that Petitioner described as most taxing, in terms of the need for force and the resulting hand fatigue. He incorrectly assumed that Petitioner spent most of each workday serving food. Dr. Vender questioned the diagnosis of carpal tunnel syndrome based in part on Petitioner's alleged failure to report night symptoms. Petitioner did in fact report such symptoms to Dr. Heller. Dr. Vender did not express any awareness of Petitioner's positive response to bilateral carpal tunnel releases. Nor did he acknowledge Dr. Heller's operative finding of median nerve compression. Dr. Vender's testimony that carpal tunnel syndrome is merely a "condition of inconvenience" that never requires work restrictions is simply not credible.

While the parties did not technically place medical in dispute, Petitioner's testimony establishes that her group carrier paid her medical expenses. Those expenses totaled $7,963.00 according to the Request for Hearing form. The Arbitrator has already found that Petitioner established causation as to the need for surgery. The Arbitrator finds that Respondent is entitled to Section 8(j) credit for the group carrier payment. Respondent is to hold Petitioner harmless against any claims made by the group carrier.

What is the nature and extent of the injury?

This is a pre-amendatory case, since Petitioner's symptoms manifested prior to September 1, 2011. In assessing permanency, the Arbitrator considers Dr. Heller's finding of a successful surgical outcome along with Petitioner's credible testimony that the surgeries relieved her hand pain but not her hand weakness. Petitioner indicated her hands get tired after she writes for a few minutes and she feels as if her hands are about to give out when she carries heavier items such as milk crates.

The Arbitrator finds that Petitioner is entitled to permanency equivalent to 12.5% loss of use of each hand under Section 8(e) of the Act. The Arbitrator awards a total of 51.25 weeks (25.625 weeks for each hand multiplied by two) of permanency benefits.

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 Frederick,

Petitioner,

vs. NO: 13WC 00582

16IWCC0453

Lisa Frederick and Michael Frederick,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, prospective medical, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 4, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 30 2016
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DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

FREDERICK, MICHAEL
Employee/Petitioner

Case# **13WC000582**

16IWCC0453

LISA FREDERICK AND MICHAEL FREDERICK
Employer/Respondent

On 12/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

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2461 NYHAN BAMBRICK KINZIE & LOWRY
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16IWCC0453

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MICHAEL FREDERICK
Employee/Petitioner

v.

LISA FREDERICK AND MICHAEL FREDERICK
Employer/Respondent

Case # 13 WC 00582

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch,** Arbitrator of the Commission, in the city of **Chicago,** on **8/6/2014.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Vocational Rehaibilitation**

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FINDINGS

On, **June 23, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner's average weekly wage was **$0.00**.

On the date of accident, Petitioner was **33** years of age, *married* with **2** dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has not* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$38,814.29** for TTD, **$0** for TPD, **$0** for maintenance, and **$2,783.12** for other benefits, for a total credit of **$41,597.41**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Claim for compensation denied. Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on June 23, 2011.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

November 30, 2015
Date

DEC 4 - 2015

FINDINGS OF FACT

Petitioner was employed by Respondent as a commercial satellite and data communications technician. Respondent was run by Petitioner's wife, Lisa Frederick. Petitioner was a part-owner of Respondent with his wife since 2009 or 2010. From time-to-time over the years, the company employed other technicians in addition to Petitioner. Lisa Frederick maintained the company records, also doing contracts, payroll, scheduling jobs and allocating technicians.

Petitioner is left handed. He was 33 years old on the date of the alleged accident.

Petitioner's job consisted primarily of installing satellite dishes for applications such as lottery machines. He would lift 35-200 pounds, carry and climb a ladder, hang and pull overhead cables, fish cables through walls, bend, stoop, kneel and crawl in confined spaces, along with carrying the cable, receiver dish and cinderblocks. Petitioner had hands on training in this trade. He had a high school education.

Petitioner testified that on June 23, 2011, he injured himself when he fell from a ladder while exiting a 10-foot ceiling onto an eight foot ladder at a K-Mart store located at 51st and Kedzie in Chicago. He testified that he landed on the tile floor (hands first, then his knees). No one witnessed the fall. Petitioner testified that after landing, he noticed that he cut his left wrist and his shoulders, neck and knees hurt. He testified that this incident occurred around 4:30 p.m. and that after the fall, he climbed a ladder to the roof of the building and took photographs of the work that he had completed on the roof, as was required. Petitioner identified Petitioner's Group Exhibit 21 as a true and accurate copy of these photographs. The photos show the Illinois Lottery Number and the date. Petitioner was working this job by himself.

Petitioner testified that although he had a camera, he did not take any photographs of the scene of his alleged accident or his alleged injuries. He testified that he told a woman at the K-Mart Customer Service desk that he had fallen, but that he did not complete any report. He testified that the woman asked him if he wanted to complete a report and he declined. He testified he reported the incident to his wife later that evening and that his wife did not ask him to complete any accident report. He testified he did not complete an accident report.

Petitioner testified that he continued working after June 23, 2011, and that he did not seek any medical attention until "the end of October 2011." The job spread sheet that Petitioner submitted shows that Petitioner completed installations on June 24, June 26, June 27 and June 29, 2011. Thereafter, Petitioner began working with another tech, Richard Franks, beginning July 18, 2011. (Pet.Ex. 22) There was no testimony regarding the gap in installation jobs for Franks and Petitioner between June 29, 2011 and July 18, 2011.

Petitioner testified that during this time, he was working slower and Franks did the heavy work. He noticed that his shoulder, neck, knees and left hand hurt. He thought that he would get better.

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The medical records from Petitioner's primary care physician, Walter Fritz, M.D., of Knox-Winamec Community Health Care, show that Petitioner was seen on August 22, 2011 (some 6 weeks after the alleged accident) for an URI, and made no mention of any injuries from a June 23, 2011, fall. The doctor failed to note any injuries or limitations regarding Petitioner's left shoulder and left 5th finger at this time. (ResEx. 5)

Petitioner testified that he called Dr. Fritz's office in late October of 2011 and was advised to go to the emergency room.

On November 7, 2011, Petitioner presented to Starke Memorial Hospital emergency room. At that time, he gave a history of injuring himself in August of 2011 (8/11/2011), when he fell off of a stepladder. The records from Starke Memorial Hospital do not make any reference to a June 23, 2011, work accident. Petitioner complained of pain in both wrists, both shoulders and both knees and stated pain was worse in the left shoulder and left wrist/hand. X-rays of the left and right wrists, left hand, left shoulder and left and right knees were taken and he was discharged from the emergency room. The discharge diagnosis was strain of the rotator cuff of left shoulder and sprain of the left wrist.

On November 14, 2011, Petitioner returned to Knox-Winamec Community Health Center. Petitioner gave a history of injuring himself on August 11, 2011, while "crawling out of an attic space and onto a stepladder". There was no mention of a June 23, 2011, work-related accident. (PetEx. 7)

Petitioner received no further medical treatment until November 29, 2011. On that date, he was seen by Dr. Anthony McPherron of Specialty Orthopedics, Inc. on a referral by Dr. Fritz. The history was of falling on August 11, 2011, "while coming out of an attic." There was no mention of a June 23, 2011 work-related accident. Dr. McPherron ordered an MRI of the left shoulder and left hand. Petitioner underwent those diagnostic studies on December 6, 2011. (PetEx. 11)

Dr. McPherron referred Petitioner to Dr. Thomas Magill of LaPorte Orthopedics. The chart from Dr. Magill dated January 4, 2012, contains a history of an August 11, 2011, fall, while working. There is no mention of a June 23, 2011 accident. Petitioner was seen by Dr. Magill for a surgical consult regarding his left shoulder and left hand. There is no mention of neck complaints and the neurologic exam was unremarkable and the Spurling's sign was negative. (PetEx. 11)

On January 16, 2012, Starke Hospital's initial occupational therapy evaluation contains a history of an August 11, 2011, fall and no mention of a June 23, 2011 work accident. (ResEx. 2)

On January 19, 2012, Dr. Magill performed left shoulder surgery consisting of left arthroscopy with arthroscopic Bankart repair. Post-operative diagnosis was left shoulder anterior instability. The surgical report showed the rotator cuff was in very good condition. (ResEx. 3)

Thereafter, Petitioner underwent a course of rehabilitation and occupational therapy.

Petitioner testified that he was seen at Starke Hospital on March 29, 2012, relative to complaints of back pain that began "while on a tractor on March 28, 2012."

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On April 6, 2012, Petitioner was examined by Dr. Todd Graham on a referral by Respondent's insurance carrier. Petitioner gave a history of an August 11, 2011, accident and there was no mention of a June 23, 2011, accident. At that visit, he complained of left shoulder pain, bilateral wrist pain, bilateral knee contusions and neck pain.

On May 7, 2012, Petitioner was seen at Starke Hospital again relative to an injury to the neck "while working in his barn."

On May 14, 2012, Petitioner was seen at Starke Hospital again with complaints of increased pain "while sitting on the bleachers over the weekend."

On May 14, 2012, Petitioner saw Dr. Mencias at South Bend Orthopedics relative to complaints of pain in his left hand and left wrist. The records document a history of an August 11, 2011, fall from a ladder and contain no mention of any June 23, 2011 work-related accident. The doctor diagnosed left cubital tunnel syndrome.

On May 21, 2012, Petitioner was seen at Starke Hospital. He complained of neck pain "while working in the garden and taking care of his neighbor's horse over the weekend."

On June 1, 2012, Petitioner presented to Starke Hospital with complaints of left shoulder pain due to "rolling over while sleeping."

On June 5, 2012, Dr. Mencias performed left cubital tunnel release and left small finger extensor tendon surgery. On June 25, 2012, Petitioner underwent an occupational therapy evaluation at Apex Therapy. These records again document a history of an August 11, 2011, fall and do not make mention of any June 23, 2011, accident.

On November 5, 2012, Dr. Mencias released Petitioner to return to regular duty work and found him to be at maximum medical improvement relative to both wrists.

On December 28, 2012, Dr. Graham released Petitioner to return to regular duty work and found him to be at maximum medical improvement for the neck.

On January 3, 2013, Petitioner signed and caused to be filed an Application for Adjustment of Claim in this matter. Petitioner identified Respondent's Exhibit 1 as a true and accurate copy of the Application containing his signature and alleging a June 23, 2011 date of accident. This is the first document that lists any alleged accident date of June 23, 2011. (ResEx. 1)

As noted above, no doctors documented a history of a June 23, 2011 accident before the January 3, 2013, filing of the Application for Adjustment of Claim. Rather, nine treating doctors and providers documented very specific histories of an August 11, 2011 fall from a ladder. The records from Starke Hospital also document other histories of injuries or onsets of pain at Petitioner's home, but nothing about a June 23, 2011 work-related accident.

Petitioner's history of accident changed after the filing of the Application for Adjustment of Claim. All treating and examining doctors after that date documented a history of a June 23, 2011,

work-related accident. Interestingly, the records from Dr. Fritz contain what appears to be an amended history, noted on February 14, 2013. Apparently, the history is changed from an 8/11/2011 fall at home to a 6/23/2011 fall at the K-Mart at 51st and Kedzie. The history is said to be "significantly complicated and prolonged." (ResEx. 3)

Dr. Fritz referred Petitioner to Dr. Ring, a pain medicine doctor. Dr. Ring is board certified in anesthesiology and specializes in interventional pain medicine. Dr. Ring testified via evidence deposition at Petitioner's request. (PetEx. 20) On February 27, 2013, Petitioner presented to Dr. Ring and completed a pain questionnaire. At that time, he gave a history of falling in June of 2011. Petitioner sought treatment for left and right shoulder pain, left and right knee pain, left hand pain and neck and back pain. Dr. Ring administered epidural steroid injections and trigger point injections. Dr. Ring testified to a causal connection between the accident of falling off a ladder onto the floor and Petitioner's condition of ill- being that the doctor was treating him for. (PetEx. 20)

On April 23, 2013, Dr. Fritz found that he was unable to offer Petitioner additional treatment or medications.

On May 21, 2013, Petitioner was examined at Respondent's request by Dr. Kenneth Candido. Dr. Candido testified via evidence deposition at the request of Respondent. (ResEx. 4) Petitioner gave a history of a June 23, 2011 fall to the doctor. Dr. Candido is board-certified in the area of anesthesiology and pain medication. The doctor diagnosed: (a) status post complete tear of the extensor tendon of the left fifth finger; (b) status post left complete labral tear; (c) left shoulder incomplete impingement syndrome. Dr. Candido opined that Petitioner's complaints and condition of ill-being relative to the left fifth finger and left shoulder would be causally related to the incident Petitioner alleged of a June 23, 2011, fall from a ladder. He testified that Petitioner's complaints and alleged current condition of ill-being relative to the cervical spine were not causally related to the work injury described. In this regard, he found no correlation between Petitioner's alleged slip and fall from the ladder and any subsequent cervical radiation problems associated with a very minimal disc protrusion noted on the MRI of the cervical spine and dated December 26, 2012. The doctor also based his opinion on the fact that there were no documented complaints of cervical pain for several months after the alleged fall from the ladder. Dr. Candido opined that the Petitioner had reached maximum medical improvement and that Dr. Ring's recommendations for additional medical treatment were not medically necessary and appropriate. (ResEx. 4)

On October 10, 2013, Petitioner was seen by Dr. Michael Malek on referral from Dr. Ring. Dr. Malek recommended a lumbar spine MRI and cervical spine MRI and EMG/NCV of the bilateral upper extremities. An October 29, 2013, MRI of the lumbar spine revealed a small broad-based disc bulge with right annular tear at L5-S1. The MRI of the cervical spine was essentially normal with a mild protrusion at C6-7. Dr. Malek advised the Petitioner that cervical fusion and lumbar fusion were options. (PetEx. 18) Petitioner wished to get a second opinion.

On January 29, 2014, Petitioner was seen by Dr. Dwight Tyndill of Orthopedic Specialties of Northwest Indiana on referral from Dr. Malek. Dr. Tyndill concluded that the MRI of the cervical spine and lumbar spine failed to show any significant pathologies. The paucity of clinical findings, along with the MRI findings, would not support that the patient would benefit from surgery. (PetEx. 19)

M. Frederick v. Lisa Frederick, et al , 13 WC 00582

At trial, testimony was provided by Petitioner's wife, Lisa Frederick. She testified that the Respondent company was run through her social security number and that she maintained records of payroll. She identified Petitioner's Exhibit 22 as a document she created from her computer, detailing Petitioner's installations. She also prepared Petitioner's Exhibit 23, a spreadsheet detailing Richard Franks' installations. She testified that no Notice of Accident was completed. She testified that the lottery contract for Respondent ended in January of 2012. The business terminated thereafter, because they had no installers and, apparently, no work. Lisa Frederick recalled that Petitioner called her from his hotel in late June of 2011 and told her that he had fallen at a K-Mart.

Petitioner also presented testimony from Richard Franks. Mr. Franks appeared pursuant to subpoena and testified that he previously worked for Respondent from the middle of 2009 until January of 2012. Mr. Franks testified that he was paid by Respondent via direct deposit. He did not recall any specific conversations in which Petitioner related a specific work-related accident date to him. He did recall that Petitioner slowed down and needed assistance on jobs. Franks was disabled after a car accident in January of 2012.

Petitioner offered his claimed medical bills into evidence as Petitioner's Group Exhibit 6. These bills were all objected to by Respondent. Respondent was to be allowed a credit for all bills that it paid. Petitioner's Exhibit 5 was claimed prescription bills. Petitioner's Exhibit 4 was a spreadsheet to support a claim for mileage expense reimbursement.

Petitioner takes several medications. He does limited housework and yardwork. He has pain. The pain is constant. It is in both shoulders, both knees, both elbows, his left hand and his neck and back. He has difficulty lifting. Driving causes swelling and pain. Walking down stairs causes pain. Standing hurts him. Stooping, kneeling, bending or reaching causes pain.

Petitioner did not work after October 27, 2011. Petitioner received workers' compensation benefits through December of 2012. He tried to look for light duty work, but was unsuccessful. He has not been offered vocational rehabilitation. He lives in a rural area of Indiana.

Petitioner testified that Respondent received $280.00 for an installation and Petitioner received cash payment from Respondent for the installation jobs. According to Petitioner's Exhibit 22, Petitioner would receive $160.00 per installation. He testified that he was paid when Respondent received payment for the installations. Petitioner tendered his 2010 and 2011 income tax forms as Exhibits 1 and 2. These documents show that Petitioner had business income (Michael K. Frederick, proprietor), but received no wages. The businesses did not pay any wages, per the Schedule C's.

Petitioner admitted to giving the histories of an accidental fall in August of 2011 (and providing the specific date of August 11, 2011) to the various medical providers set forth above. Petitioner looked up the specific date of June 23, 2011 after TTD benefits were stopped in December of 2012. Petitioner's Exhibit 22 does show that Petitioner had an install at K-Mart on 51st and Kedzie on the afternoon of June 23, 2011.

M. Frederick v. Lisa Frederick, et al , 13 WC 00582

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

In support of the Arbitrator's Decision relating to Issue (A), was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act, the Arbitrator finds as follows:

The Arbitrator finds that Respondent was operating under and subject to the Act on June 23, 2011, based upon the testimony of Petitioner and Lisa Frederick and Petitioner's Exhibit 22. As the alleged accident occurred in Illinois, the jurisdiction of the Illinois Workers' Compensation Commission is provided for in § 1(b)2 of the Act.

In support of the Arbitrator's Decision relating to Issue (C), did an accident occur that arose out of and in the course of Petitioner's employment by Respondent on June 23, 2011, the Arbitrator finds as follows:

Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent of June 23, 2011.

First, Petitioner failed to seek emergency care for his alleged injuries, which included a complete rupture of the left 5th finger extensor tendon and trauma to the left shoulder which resulted in a labral tear and Bankart procedure, eventually leading to conditions of both knees, shoulders, wrists, and the neck and back which disable Petitioner from working in any capacity beyond light duty, on the day of the alleged accident or at any time close to June 23, 2011.

Second, the initial medical care took place some 4-1/2 months after the alleged accident (November 7, 2011) and the history given was of a fall in August of 2011 (not June 23, 2011). The initial histories do not say that the fall occurred while working. The history of an accident in August of 2011 was maintained for over a year, until January of 2013. The amended history noted by Dr. Fritz on January 14, 2013 appears to document that the original history was of an August 11, 2011 accidental fall occurring at home.

The gap in time for treatment is too long. The histories given to too many providers fail to confirm a work related accident on June 23, 2011. The Petitioner's testimony regarding why he told nine medical providers of the wrong accident date is not persuasive.

Given the above, The Arbitrator cannot find that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on June 23, 2011. The claim for compensation is, therefore, denied.

M. Frederick v. Lisa Frederick, et al , 13 WC 00582

In support of the Arbitrator's Decision relating to Issue (F), is Petitioner's current condition of ill-being causally related to the alleged June 23, 2011, injury, (G), what were Petitioner's earnings, (J), were the medical services that were provided Petitioner reasonable and necessary, (K), is Petitioner entitled to any prospective medical care?, (L), what temporary total disability benefits are owed ?, (M), penalties, and (O), vocational rehabilitation, the Arbitrator finds as follows:

As the Arbitrator has found that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on June 23, 2011, the Arbitrator needs not decide these issues.

Regarding the finding above regarding average weekly wage, the Arbitrator notes that Petitioner's tax forms (Petitioner's Exhibits 1 and 2) show that Petitioner received no wages and his business (Michael K. Frederick, proprietor) paid no wages. A claimant's business income should not be considered in calculating the average weekly wage under §10 of the Act. See: Mansfield v. Illinois Workers' Compensation Comm'n , 2013 IL App (2d) 120909WC.

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

Ana Gonzalez,

Petitioner,

vs. NO. 12WC002308

Testors,

16IWCC0454

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, causal connection, medical expenses, prospective medical care, permanent disability, penalties and fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 31, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond is required for 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: JUN 3 0 2016
SJM/sj
o-6/23/16
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0454

GONZALEZ, ANA
Employee/Petitioner

Case# **12WC002308**

TESTORS
Employer/Respondent

On 8/31/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.20% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0445 RODDY LAW LTD
CHRISTOPHER TOMCZYK
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

16IWCC0454

- [ ] 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

Ana Gonzalez
Employee/Petitioner

v.

Testors
Employer/Respondent

Case # 12 WC 2308

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Rockford & Woodstock**, on **June 18th & July 1st, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] 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. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **10-7-11**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$20,641.92.**; the average weekly wage was **$396.96**.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$7,599.43** for TTD, **$0** for TPD, **$0** for maintenance, and **$2,860.00** as an advancement on permanent partial disability benefits, for other benefits, for a total credit of **$10,459.43**.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to Petitioner and her attorney per Rule 7080.20 up until the July 2, 2012 date of service, as provided in Sections 8(a) and 8.2 of the Act. All treatment thereafter shall remain the responsibility of the Petitioner.

Respondent shall be given a credit of **$7,599.43** for TTD benefits previously paid, and **$2,860.00** as an advancement on permanent partial disability benefits, for other benefits, for a total credit of **$10,459.43**.

Respondent shall pay Petitioner temporary total disability benefits of $286/week for 27 weeks, commencing 11/27/11 through 5/31/12, as provided in Section 8(b) of the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no opinion comporting with the specific requirements of §8.1b(a) was submitted into evidence

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, Petitioner was assembler/ packer and that she able to return to work in her prior capacity for over two years. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 40 years old at the time of the accident. The Arbitrator therefore gives less weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the petitioner continues to work in her full duty position therefore no weight is given.

With regard to subsection (v) of §8.1b(b), Dr. Hastings returned the petitioner back to normal work activities. Because she has been working those activities for nearly two and a half years post treatment, the Arbitrator therefore gives *greater* weight to this factor.

Based on the totality of the evidence, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10 % loss of use of each hand pursuant to §8(e)9 of the Act which shall be paid to Petitioner and his attorney.

As noted above, Respondent shall be due a credit of $2,860.00 on payment of future benefits due under this Award based upon the total credit of compensation previously paid.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

#01 George Andros
Signature of Arbitrator

August 26,2015
Date

AUG 3 1 2015

STATEMENT OF FACTS 12 WC 2308

Petitioner was employed by Respondent since 2005. Her job duties and responsibilities were in the packing & assembly department. She would work on different lines during the course of the day but that her job duties would involve grasping and moving of small parts. An example of one of her jobs would be to use markers and grabbing tiny rubber bands to the tip and place them into the markers. Her typical work day lasted 8 hours a day; however, she would have to switch lines every hour. She would work on three lines during the course of her employment up to the date of the accident. There were no quotas in her job but gave an example of one line having a total production of 18,000 units in a day. Her shift was 8 hours and her line would be running the entire day.

Petitioner testified on September 20, 2011 she experienced cramping into her fingers and both hands with tingling. She was sent to the company clinic that day. The medical records reflect that Petitioner was seen on September 20, 2011 at Crusader Health Clinic and seen by Dr. Hagemeyer (PX. 1). Petitioner testified that her hand had been getting bad for approximately three months and decided to make a report because of the increased pain. EMG taken on September 28, 2011 was read as median nerve entrapment and neuropathy at both wrists. On October 4, 2011 Dr. Hagemeyer confirmed the diagnosis of carpal tunnel syndrome; He referred her to Rockford Orthopedic Clinic for treatment.

However, she was treated at Physicians' Immediate Care on 10/21/11 giving history of bilateral hand pain. The diagnosis was work-related left and right hand paresthesia. PIC pronounced she could return to work full duty. She returned on October 29, 2011 and indicated Petitioner could start working with no lifting over 5 pounds. By November 11, 2011 the Petitioner was still at work and was referred to Dr. Hastings.

Dr. Hastings confirmed on 11/30/11 she failed conservative care and treatment and recommended surgery. Petitioner underwent her first surgery on February 22, 2012 to her right hand. Thereafter, Petitioner underwent left carpal tunnel surgery on March 28, 2012. Post FCE he released her to return to work on May 31, 2012 per the FCE results. On July 2, 2012 he released her to return to work full duty.

Petitioner returned to full duty work on July 3, 2012. She asserts continued pain in her hands, however, confirmed that the pain was different than prior to after the accident. Petitioner testified that after her surgery she still had severe pain in both of her hands as well as now developing pain into her elbows and arm region. Petitioner specifically stated that the pain began in her wrist and would travel up her left arm to her elbow and up her right arm to the shoulder region.

Petitioner saw Dr. Mass in Chicago on July 24, 2012 who indicated Petitioner might still be healing from the surgeries. Petitioner thereafter returned to Crusader Health Clinic on August 7, 2012 due to continued complaints of pain. The doctor at Crusader Health Clinic advised Petitioner that no further treatment could be performed with return to work full duty.

Petitioner then returned to the company clinic, Physicians' Immediate Care on January 25, 2013. She was again diagnosed with carpal tunnel syndrome and advised to avoid strong gripping. PIC issued a fitness for duty certificate of return to work with limitations. Petitioner testified that she presented the note to Cindy Stowell, of the Human Resource Department, and was told that there was no light duty work available for her at that time. After that exam the petitioner underwent an section 12 exam at the behest of Respondent by Dr. Michael Vender. After a subsequent EMG was performed at the request of Dr. Vender, Petitioner eventually return to work on September 24, 2013. Petitioner had attempted to return to Dr. Hastings to seek additional treatment but the doctor refused to see her, indicating there was no more treatment he could offer her.

Petitioner confirmed she returned to work on September 24, 2013. She returned to work with no limitations at that time and was able to perform all the duties of her job. She has continued to work for Respondent since September 24, 2013 up to the date of the hearing. She has continued to work full duty throughout that timeframe.

Petitioner testified she was not paid temporary disability benefits from January 25, 2013 to September 23, 2013. Petitioner indicated upon her return to work she still has pain in her elbow and pain in her right shoulder. She continues to have pain and numbness in both of her hands.

Petitioner, at the request of her attorney, had an examination with Dr. Zachary, of University of Wisconsin Health on May 5, 2014. She indicated she had no physical therapy for her surgery and her condition and the doctor recommended further treatment. The last visit with Dr. Zachary was July 7, 2014 and she has not received further treatment. Petitioner testified on direct examination that she did not receive any further treatment because she no longer had access to her husband's group health insurance.

At the time of hearing, Petitioner had left arm pain which extends into her elbow and right arm pain that extends from her right shoulder. She also complaints of a bump on the inside part of her wrist on her left hand which is by her thumb and index finger. She has complaints of pain, but very little complaints of numbness. On the right hand side her three fingers, index, middle and ring, get "rigid." She also experiences numbness and cramps.

On cross-examination, Petitioner testified she had group health insurance from her husband throughout the year of 2013 and up until the end of her visits with Dr. Zachary in 2014.

Despite having access to that insurance contrary to her testimony on direct examination, she sought no additional medical treatment at that time. She admits that she has been able to perform her jobs without difficulty for Respondent since being release from treatment in 2012 until the present time. Petitioner further admitted on cross-examination that her current complaints of pain are different than those experienced after her accident and prior to her surgeries. Specifically, she now has pain on her left arm up to her left shoulder and pain to her elbow on the right hand side. Both of these complaints of pain were not present at the time of her injury.

Petitioner further confirmed when she returned to work in September of 2013 no doctor told her to do so. She admitted that she went back to work of her own accord.

Ms. Stowell, a Respondent witness, testified that she was employed as manager of human resources on the accident date. She was familiar with Ms. Gonzalez and her case. Ms. Stowell testified that on January 25, 2013 she was contacted by the petitioner regarding a work limitation she received a Physicians' Immediate Care. She identified PX. 2, Page 23,and Resp. Ex. 4, as a form she received from Physicians' Immediate Care. She testified those limitations could have been accommodated by Respondent due to the return to work clearance given by the physician. She confirmed that that position would have paid the petitioner exact wages as she would have in her normal employment. She further indicated that the position was offered to Ms. Gonzalez but that position was refused by her. Ms. Stowell further confirmed that Petitioner returned to work in September of 2013. Upon questioning from the Arbitrator, Ms. Stowell clarified that in the prior time where Petitioner was off work with Dr. Hastings, the petitioner did not obtain a fit for duty work note from Physicians' Immediate Care when she was on prior light duty work. At the January 25, 2013 visit, Petitioner did obtain a Fitness for Duty work note. Thus, by her testimony the Respondent could have accommodated her light duty work restrictions at that time due to the fitness for duty note.

CONCLUSIONS OF LAW

Issue of Causation:

While the majority of the facts in this case are undisputed, it appears the center of the controversy surrounds Petitioner's additional complaints of pain following her release from her current treating surgeon, Dr. Hastings. It is Petitioner's position that she continues to have bilateral hand pain as a result of her original injury and that she requires further medical treatment. It is Respondent's position that Petitioner does not require further medical care after her surgery due to her original accident and all treatment after the release from work by Dr. Hastings is not reasonable or causally related to her work injury.

Based upon the totality of the evidence, , the Arbitrator hereby finds as a matter of fact in the case at bar that the Petitioner had reached maximum medical improvement from her injury when she was released from Dr. Hastings in July of 2012.

In making this determination, the Arbitrator adopts the records and opinions of Dr. Hastings. Dr. Hastings had an accurate history of Petitioner's treatment and complaints as well as all relative medical records regarding her care and treatment. Ms. Gonzalez was known to Dr. Hastings and had many visits with Dr. Hastings. His medical records at the time the FCE was ordered indicate he felt her "symptoms were out of proportion to what he would expect...". In addition he commented that she could not touch the thenar eminence and proximal aspect of the hand, but could hold paperwork in that hand at the end of the examination. (PX. 3, p 51)

Upon review of the FCE report, the Arbitrator notes there were many inconsistencies noted within this examination. In fact it is noted that 66.7 percent of the exam was inconsistent. (Pet Ex 3 Pg 59) Of note she indicated no sensation in her fingers but had no difficulty with fine motor movements on exam. In addition she demonstrated an extremely low grip test tolerance but was able to grasp weights when asked to do so in the exam. (Pet Ex 3 pg 64) When the Petitioner returned in July 2, 2015 he felt she could return to work full duty.

This exam was also reviewed by Respondent's IME doctor, Dr. Vender, who after a repeat EMG , also felt Petitioner was at maximum medical improvement, need no further treatment for her sustained injury, and felt her ongoing complaints were greater than the objective findings. Petitioner testified that she performs full duty since September 2013.

Dr. Mass was originally hired by Respondent to give a causation opinion. It is the second period of contention in which Petitioner relies upon his reports. While Dr. Mass did examine the petitioner in July of 2012, he did not have the benefit of her other medical records and FCE examination. He only had the subjective complaints of Petitioner. In addition, Dr. Zachary subpoenaed medical records only have her complaints of pain and the notes of the prior surgeries and EMG reports. (Pet Ex 5, pg 136) A critical examination of the records reveal that while the petitioner claimed of numbness in her hands - Dr. Zachary's examination notes "grossly intact to light tough". Her examination in fact looks normal except for her pain complaints. (Pet Ex 5 pg 141) Upon review of the EMG report performed at the request of Dr. Zachary, this Arbitrator notes the EMG technician indicated that "changes in the median nerves may only indicate prior carpal tunnel syndrome." (Pet Ex 5 Pg 153) This does not indicate whether Petitioner's current problems are being related to her original injury or if this is a new finding. No opinion of Dr. Zachary links her current complaints to the October date of accident. (Pet Ex # 5, pg 140-151) In fact there seems to be only a recommendation made for further therapy; there is no basis on causation for the need of more treatment. (Pet Ex 5 Pg 147-149).

Based upon the totality of the evidence,, the Arbitrator finds the opinion of Dr. Hastings and Dr. Vender more persuasive in the case at bar over that of Dr. Zachary. Dr. Hastings was Petitioner's treating physician and is much more knowledgeable as to her care and treatment and habits while examining her multiple times. Dr. Zachary only had two examinations with Petitioner and was not privy to her prior treating notes. Likewise, Dr. Vender was provided all her treating records and history and was able to review the same, providing a more complete picture of Petitioner's medical history.

Based upon the totality of the evidence, the Arbitrator finds as a matter of fact and as a conclusion of law that Petitioner's current condition of ill-being is not causally related to her accident of October 7, 2011. The Arbitrator further holds any care and treatment rendered after released from her original treatment of Dr. Hastings on July 2, 2012, is not causally related to her condition.

Issue of TTD Benefits:

The main issue in dispute is from January 2013 until September of the same year. Petitioner is alleging that she is owed TTD benefits from January 23, 2013 until she returned to work on her own on September 24, 2013.

Based upon the totality of the evidence, the Arbitrator finds as a matter of fact and as a conclusion of law that Respondent is not liable for TTD benefits for this time period. The conclusion on causation above plus the testimony of Ms. Stowell is underscored.

Based upon the totality of the evidence presented to this Arbitrator on Petitioner's causal connection and the testimony of the witness of Respondent, the Arbitrator finds that Respondent is not liable for payment of TTD benefits from January 24, 2013 until September 24, 2013. It appears, based upon the evidence, Respondent would have had light duty work available for Petitioner and it was refused by Petitioner at that time. The Arbitrator specifically notes that Ms. Stowell testified that the reason Respondent could not originally accommodate any light duty work of Petitioner was that she did not obtain a Fitness for Duty note from Physicians' Immediate Care, the "doctor's clinic" of Respondent. Had she done so, work would have been available. A review of the medical records from Dr. Hastings confirms this testimony as Dr. Hastings records reflect the Petitioner attempted to obtain such a statement in May of 2012 and was not given a fitness for duty note. (Pet EX 3 pg 51) As this note confirms the testimony of Ms. Stowell, the Arbitrator finds her testimony very persuasive. In addition, the Arbitrator's findings on causal connection of her current condition would hold Respondent not liable for Petitioner's off work and medical condition at that time.

In regard to the period of TTD from November of 2011 until July of 2012, the Arbitrator notes that Physicians Immediate Care allowed the Petitioner to return to work in November with a 1lb lifting restriction and per the history given to the Doctor she had been performing her work duties with assistance from co-workers. Based upon the medical notes the Arbitrator finds that TTD disability benefits should have begun on November 27 2011.

Petitioner is claiming benefits would be due until July 3, 2012 the day she returned back to work. However, the medical notes clearly indicate Dr. Hastings informed her she could return to work on May 31, 2012. (Pet Ex 3 pg 52) The medical notes further indicate that the return to work imitation imposed upon the Petitioner was that of her full duty activities. (Pet Ex 3 pg 53) There has been no testimony that the Petitioner would have required any fitness for duty upon a return to full duty work, and in fact the testimony that the Petitioner was able to return to work on her own in September of 2013 without one would confirm the same. Therefore the Arbitrator finds that the Petitioner would be entitled to TTD benefits until May 31, 2012.

Wherefore, the Arbitrator finds as a matter of fact and conclusion of law that Respondent is only liable for payment of temporary total disability benefits from November 27, 2011 to the time she was released for work by Dr. Hastings in May 31, 2012. Respondent shall be due a credit of the remaining weeks due until Petitioner returned to work.

Issue of Medical Benefits

Based upon the determinations above on causal connection, the Arbitrator hereby finds that the Respondent is only liable for the reasonable and related medical care rendered to Petitioner from the date of accident up until she was released by Dr. Hastings in July 2, 2012.

Issue of Penalties:

Based upon the totality of the evidence, the Respondent has made a good faith challenge to the Petition for Penalties.

Wherefore, based upon the totality of the evidence, penalties are denied.

Issue of Nature and Extent of Injury:

Based upon the totality of the evidence, and under the Statute as amended, the Arbitrator finds as a matter of law this Petitioner is entitled to ten percent loss of use of the left hand plus ten per cent loss of use of the right hand.

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

Willie Franklin,

Petitioner,

vs. NO. 10 WC 38362

Jacksonville School District 117,

Respondent.

16IWCC0455

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, TTD, causal connection, PPD and credit for TTD benefits paid due to Respondent 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 incorrectly calculated the credit due to Respondent as $13,400.42. Review of Respondent's Exhibit #1 introduced into evidence at hearing reveals that two checks for TTD benefits written to Petitioner on November 30, 2010, and one check written for TTD benefits on September 14, 2010 were, in fact, void. Each of the three checks was in the amount of $987.40 for a total of $2,962.20. These funds were not paid to Petitioner. The arbitrator failed to note the fact that these checks were void and failed to adjust the credit due to Respondent for TTD benefits paid to $10,438.22

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is due a credit of $10,438.22 for TTD benefits paid to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Arbitrator's denial of Petitioner's claim is affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit

16IWCC0455

for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 3 0 2016
o-5/5/16
SM/msb
44

Stephen Mathis

Mario Basurto

David Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRANKLIN, WILLIE
Employee/Petitioner

Case# **10WC038362**

JACKSONVILLE SCHOOL DISTRICT 117
Employer/Respondent

16IWCC0455

On 8/24/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% 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:

0834 KANOSKI BRESNEY
CHARLES EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

2396 KNAPP OHL & GREEN
DAVID GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

16IWCC0455

☐ 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

WILLIE FRANKLIN
Employee/Petitioner

Case # 10 WC 38362

v.

Consolidated cases: N/A

JACKSONVILLE SCHOOL DISTRICT 117
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Molly Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **June 25, 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 17, 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 **$38,449.32**; the average weekly wage was **$739.41**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** children under 18.

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 **$13,400.42** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0** in non-occupational indemnity disability benefits, for a total credit of **$13,400.42**.

Respondent is entitled to a credit for **all medical benefits paid** under Section 8(j) of the Act.

ORDER

Because Petitioner failed to prove by a preponderance of the credible evidence that he sustained accidental injuries on June 17, 2010 that arose out of and in the course of his employment with Respondent, all benefits are denied.

Because Petitioner failed to prove by a preponderance of the credible evidence that his current condition of ill-being in his left shoulder, right shoulder, and low back is causally related to his alleged work accident, all benefits are denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Arbitrator Molly Dearing

August 24, 2015
Date

AUG 24 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

WILLIE T. FRANKLIN
Employee/Petitioner

v. Case # 10 WC 38362

JACKSONVILLE SCHOOL DIST. 117
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On his date of accident, Petitioner was fifty-seven years of age and employed by Respondent as a custodian. He alleges he injured his bilateral upper extremities and low back after he slipped while stripping wax off a bathroom floor at Respondent's school on June 17, 2010. Arb. X 2. Respondent disputes accident, causal connection, medical bills, prospective medical treatment, temporary total disability benefits, and the nature and extent of the injuries. Arb. X 1. The parties stipulated that Petitioner has two companion cases, 11 WC 14535 and 12 WC 42248, regarding injuries to the bilateral upper extremities.

Petitioner testified that on June 17, 2010, he was stripping the floor of old wax in the teacher's lounge bathroom of Respondent's school. He testified that, in the process of stripping the floor, the bathroom floor became slippery. Petitioner testified that as he stood up from scraping behind a toilet, he slipped and fell against the wall and to the floor, outstretching both of his arms to break his fall. He testified that Greg Elliot was present when he fell. Petitioner testified that his arms, "butt", and coccyx began hurting, but he stated that he cannot recall how he felt on the date of his accident upon the completion of his shift because "[b]ack then I was drinking a little bit so, you know, I'd get off, get me a drink and I guess I'd be all right and then I'd wake up and start feeling pain again." Petitioner testified that he reported the accident to Respondent on June 17, 2010, and he stated that he reported bilateral shoulder pain and low back pain to Company Nurse, which is Respondent's mechanism for reporting work accidents, the following day, at which time he was instructed to present to Respondent's company physician, Dr. Robert Gordon.

Records from Company Nurse admitted into evidence reflect that on June 18, 2010, Petitioner reported that he fell on a wet floor while scraping corners and stripping the dissolving wax from the restroom floor. He complained of "lower back pain when he moves and can feel pressure in his lumbar region when he lifts things." PX 1. Petitioner testified that he informed Company Nurse of injuries to his shoulders, back, and buttocks.

On June 18, 2010, Petitioner presented to Dr. Gordon and reported that on the day prior, he was stripping floors and slipped and fell on his buttocks and left hand, which was extended behind his back. Petitioner complained of pain in his buttocks and left shoulder, and he reported that he had had a left rotator cuff repair in November 2009. He completed a pain diagram, and demonstrated experiencing pins and needles sensations in his left shoulder and to the left and right of his lumbar spine. Petitioner further reported that he had a follow-up with Dr. Romanelli for his

left shoulder condition on July 7, 2010, and that he had previously requested Dr. Romanelli return him back to full duty "although he still had weakness and lack of range of motion because of the need for money with his job as a janitor with the school district." Petitioner stated that he had similar range of motion in his left shoulder as he had prior to the work accident of June 17, 2010, as well as the same amount of weakness. He noted stiffness in his left shoulder that was not present prior to the June 17, 2010 accident. Petitioner denied any pain in the lumbar spine. Dr. Gordon diagnosed Petitioner with a sacral/coccygeal contusion and left shoulder strain. He recommended restrictions of no lifting greater than five pounds and no overhead activities with the left upper extremity, and he prescribed Naprosyn and x-rays of the sacrum and coccyx. Radiographs of the sacrum and coccyx dated June 21, 2010 were negative for any fracture. PX 1. Petitioner testified that he was provided light duty restrictions by Dr. Gordon, but those restrictions were not accommodated by Respondent. Petitioner further testified that he informed Dr. Gordon on this date that he had pain in his right shoulder.

Petitioner returned to Dr. Gordon on June 25, 2010 with continuing complaints of left shoulder pain. He noted that his lower back complaints were "notably improved". Petitioner completed a pain diagram on June 25, 2010, and indicated experiencing pins and needles in his left shoulder and on both the left and right sides of his lumbar spine. Dr. Gordon imposed restrictions of no lifting greater than five pounds and no overhead activities with the left upper extremity and he ordered Petitioner Naprosyn. Petitioner was instructed to follow-up with Dr. Romanelli. PX 1.

Petitioner presented to Dr. Ronald Romanelli on July 7, 2010 and complained of pain in both shoulders after falling on a slippery floor and landing on both arms while at work on June 17, 2010. Petitioner also complained of numbness and tingling in his hands, but Dr. Romanelli stated "this is not related to the accident." Petitioner described the weakness in his left shoulder as the same as it was before the June 17, 2010, accident. A physical examination revealed good passive range of motion of his shoulders with good internal and external rotation, a positive impingement test on the right shoulder, good strength of the right shoulder, weakness of the left shoulder "about the same as it was before," and good resistance on the left "demonstrating that the rotator cuff is still intact with forward flexion as well as abduction." Dr. Romanelli diagnosed Petitioner with a sprain of both shoulders from a recent fall and status post arthroscopic rotator cuff repair seven months prior. Dr. Romanelli administered a cortisone injection into Petitioner's right shoulder, and recommended work restrictions of no lifting greater than three to five pounds and no overhead activities with his right arm. PX 2.

Petitioner returned to Dr. Gordon on July 9, 2010. Petitioner reported that his lower back was improved, and that he began experiencing right shoulder pain about a week prior. He denied sustaining any injury or over utilization of his right shoulder. Dr. Gordon noted that Petitioner's right shoulder complaints came about "insidiously". Dr. Gordon opined that "[b]ased upon what Mr. Franklin did describe to me previous and based upon my prior evaluations, his right shoulder issues are not related to the incident of 6/17/10." Dr. Gordon noted that Petitioner was scheduled for bilateral upper extremity electromyography studies for a diagnosis of carpal tunnel syndrome, which he stated "is not related to the event of 6/17/10." Dr. Gordon diagnosed Petitioner with a history of sacral/coccygeal contusion for which he was doing well, left shoulder strain, right shoulder pain unrelated to the current case, and paresthesia of the upper extremities unrelated to the current case. Dr. Gordon recommended restrictions of no lifting over five pounds or performing activities above shoulder height with his left extremity, and he prescribed him Relafen. PX 1, RX 9.

Petitioner testified that he was uncertain as to why Dr. Gordon's notes reflect that he denied any injury to his right shoulder.

Petitioner returned to Dr. Romanelli on July 21, 2010 with complaints of ongoing bilateral shoulder pain. Petitioner complained of worsening pain in his right shoulder. A physical examination of the right shoulder revealed good strength, positive impingement test, improved range of motion, and pain against forward flexion and abduction against resistance. A physical examination of his left shoulder demonstrated good strength and some weakness of the supraspinatus. Dr. Romanelli diagnosed him with a sprain of the right shoulder, status post arthroscopic rotator cuff repair on the left shoulder, and neck pain. Dr. Romanelli noted that "I am not really sure as to the causation, as Dr. Gordon really took a detailed history of his injury." He prescribed him Norco for pain and he recommended an MRI of the right shoulder. PX 2.

Petitioner presented to Dr. Gordon on July 23, 2010. At that time, Petitioner denied any functional limitations in his low back, though he continued to complain of pain in his left and right shoulders. Dr. Gordon diagnosed Petitioner with a sacral/coccygeal contusion that was "doing very well in this regard and has no impairment in this regard", left shoulder strain for which he recommended a home exercise program, right shoulder pain, and paresthesia of the supper extremities. Dr. Gordon opined that Petitioner's right shoulder pain was "not related to this current work-related case" and stated that Petitioner's paresthesia was also unrelated to his "current case." Dr. Gordon released Petitioner to work without restrictions in regard to his low back, and he recommended restrictions of no activities above shoulder height and no lifting over five pounds with his left upper extremity. PX 1.

An MRI of the right shoulder dated July 29, 2010 revealed mild peritendonitis involving he supraspinatus tendon, a small degenerative cyst in the lateral aspect of the humeral head, and a discrete tear was not identified. PX 2.

Petitioner returned to Dr. Gordon on August 4, 2010. Dr. Gordon noted that Petitioner reported that his back was doing well and that he had no functional limitations. Petitioner reported that his left shoulder was near his post-operative baseline, but that his right shoulder continued to bother him. Dr. Gordon noted that Petitioner discussed with him his cervical spine, "although it is unrelated [to] the current case", and also evaluated Petitioner's right shoulder, "although it is not related to this current work related case...." Dr. Gordon diagnosed Petitioner with contusion of the coccyx/sacrum and a left shoulder strain/sprain. He prescribed him Vicodin with no refills and Relafen, and did not arrange for any specific follow-up visits. PX 1, RX 9.

Petitioner returned to Dr. Romanelli on August 18, 2010. Dr. Romanelli noted that Petitioner's left shoulder was improving and that his primary complaint was right carpal tunnel syndrome. Petitioner returned to Dr. Romanelli for his shoulders on September 15, 2010. Dr. Romanelli noted that Petitioner continued to complain of bilateral shoulder pain, and ordered an MRI and ultrasound of Petitioner's left shoulder. PX 2.

On October 5, 2010, Petitioner presented to Dr. Mark Greene, with whom he had been treating for his carpal tunnel injuries, and complained of bilateral shoulder pain, primarily in the right shoulder. Dr. Greene performed an injection to Petitioner's right shoulder. PX 3.

Petitioner returned to Dr. Romanelli on October 6, 2010 to review the MRI and ultrasound results. Petitioner complained of some weakness in his left shoulder mainly above seventy to ninety degrees of abduction, improving right carpal tunnel following a release and ulnar nerve transposition, and improving right shoulder. Dr. Romanelli disagreed with the MRI report on the shoulder, which revealed a possible rotator cuff tear. He opined that Petitioner did not have a torn rotator cuff and that his supraspinatus was completely intact. He diagnosed Petitioner with sprains of the left and right shoulders, but opined that Petitioner did not require a repeat surgery on his left shoulder. Dr. Romanelli ordered Petitioner to continue physical therapy with the expectation that he could return to work regarding his left shoulder in three weeks. PX 2.

Petitioner returned to Dr. Greene relative to his shoulders on October 19, 2010. Petitioner complained of right shoulder pain and reported that the injection was not successful in relieving his discomfort. Dr. Greene noted that the MRI was normal, he discussed with Petitioner the possibility of surgical intervention, and he ordered physical therapy. On October 26, 2010, Petitioner presented to Dr. Greene and reported right shoulder pain. Dr. Greene recommended an arthroscopy and probable subacromial decompression of the right shoulder. PX 3.

Petitioner returned to Dr. Romanelli on October 27, 2010. Petitioner reported that his left shoulder felt about one hundred percent, but that his right shoulder was still bothering him. He did not feel he could perform any lifting, wash chalkboards, or lift desks due to his right shoulder. Dr. Romanelli diagnosed Petitioner with persistent pain and discomfort in the right shoulder consistent with tendinosis and partial rotator cuff tear. Dr. Romanelli ordered that Petitioner undergo further physical therapy for his right and left shoulders, and he considered the possibility of undergoing another MRI. Dr. Romanelli allowed Petitioner to resume regular duty regarding his left arm and recommended no lifting more than three to five pounds of the right arm. PX 2.

Dr. Greene performed an arthroscopy, debridement, and open rotator cuff repair on Petitioner's left shoulder on December 23, 2010. Intraoperatively, Dr. Greene noted that in the supraspinatus area, an anchor had pulled away, the thread appeared loose, and the repair seemed quite thin. Due to continuing right shoulder pain thereafter, Dr. Greene performed an arthroscopy, debridement, SLAP and labral repair with subacromial decompression on Petitioner's right shoulder on January 24, 2011. PX 3, 4.

Petitioner returned to work on April 4, 2011. PX 3. Petitioner testified that he requested Dr. Greene return him to work on that date because he was no longer receiving temporary total disability benefits from Respondent. He received disability benefits from Illinois Municipal Retirement Fund once his temporary total disability benefits ceased (RX 4) and he testified that he is presently repaying the Fund on a monthly basis for those benefits received.

Petitioner returned to Dr. Greene on May 16, 2011 and reported continued right shoulder pain after returning to work. Dr. Greene noted that Petitioner exhibited full range of motion and good strength in his right shoulder, and that Petitioner was sleeping without any difficulty. Dr. Greene prescribed him pain medication and ordered him to return to physical therapy. On September 8, 2011, Petitioner returned to Dr. Greene and demonstrated full range of motion, smooth motion, and good strength on abduction, extension, and external and internal rotation. Petitioner reported sleeping well without any difficulties. PX 3.

On March 6, 2012 and December 4, 2012 Petitioner presented to Dr. Robert Parker at Springfield Clinic with complaints of bilateral arch pain. Petitioner reported on December 4, 2012 that he worked as a custodian and is on his feet all day on a concrete surface. He was assessed with plantar fasciitis and he was instructed to continuing using his orthotics. RX 10.

On December 10, 2013, Petitioner presented to Dr. James Hinchen at Jacksonville Family Medical Associates with complaints of low back pain. He reported that the prior Friday, he had lifted a box of paper and felt immediate pain in his lower back with some radiation into his hips. Petitioner also reported some improvement since that incident. He was assessed with lower back pain. Dr. Hinchen instructed him to continue his current medications, he prescribed him Cyclobenzaprine, and he ordered him to undergo therapy. RX 6.

On March 3, 2014, Petitioner presented to Dr. Darr Leutz at Springfield Clinic and reported sustaining an injury to his right knee on January 31, 2014 while he was changing lights. He complained of right knee joint pain and swelling. Dr. Leutz's assessment was unspecified lateral knee pain, acute medial meniscal tear, and a sprain of the anterior cruciate ligament. Dr. Leutz recommended an arthroscopy of the knee with medical meniscus repair and he ordered Petitioner to undergo physical therapy. RX 10.

On April 24, 2014, Petitioner presented to Dr. Anthony Griffin at Memorial Health Systems and complained of back and left flank pain that had improved. Dr. Griffin assessed him with acute left flank pain and he was instructed to return on an as needed basis. RX 1.

Petitioner testified that he currently experiences weakness in both shoulders and achiness with weather changes. He stated that he is unable to pick up his grandchildren who weigh approximately twenty five pounds. Petitioner testified that he has decreased range of motion, and that he is unable to reach his arm over his head, worse on the left than the right. He testified that he continues to have low back pain, and that the pain in his low back has been present since the fall. Petitioner stated that after returning to work following his June 17, 2010 work accident, he was not able to perform his job as he had before the work accident. Petitioner testified that he "was doing a lot of shortcutting" in his job duties due to weakness in his arms. Petitioner retired in July 2014.

Petitioner's medical records concerning treatment to his left shoulder, right shoulder, and low back prior to his work accident of June 17, 2010 were admitted into evidence.

On July 19, 1999, Petitioner presented to Passavant Area Hospital with complaints of back pain that had been ongoing for two months. Petitioner returned to Passavant Area Hospital for chronic back pain on August 25, 1999. On that date, Petitioner reported that he had injured his back several times over the previous ten years and suffered from chronic back pain. RX 7.

On September 27, 2001, Petitioner presented to Dr. Hinchen for pain in his right shoulder while wrestling with his brother. Petitioner was diagnosed with rotator cuff tendinitis of the right shoulder and was given an injection to control the pain. RX 6.

Petitioner presented to Dr. Hinchen on January 15, 2003 with complaints of low back pain. Dr. Hinchen noted that Petitioner has had low back pain for a significant period of time. RX 6. Petitioner returned to Dr. Hinchen on November 18, 2003 due to a worsening of his chronic back pain. RX 6.

Petitioner presented to Dr. Hinchen on August 4, 2005 with pain in his right forearm, neck, and shoulders following a motor vehicle accident in which he was the driver and was rear-ended. Petitioner reported that he tightened his grip on the steering wheel prior to being hit, and as a result, had pain in his right forearm, neck and shoulders. Petitioner was advised to utilize Tylenol as needed. On April 27, 2006, Dr. Hinchen removed Petitioner from work on that date due to low back pain. RX 6.

On July 27, 2009, Petitioner presented to the emergency room of Passavant Area Hospital for left shoulder pain. Petitioner's reported that he fell off his bicycle, but stated that he "does not know how he fell states he was drunk." He complained of clicking and pain with movement in his left shoulder. He was discharged home with a prescription of Naprosyn. RX 7. Petitioner returned to Passavant Area Hospital on November 17, 2009 and filed a Request for Correction/Amendment of Health Information. He requested the history of his medical note of July 27, 2009 be changed from falling off his bike to reflect that he hurt himself moving furniture at work on July 24, 2009. The amendment was accepted by the Hospital. Mary Ludvigsen, the nurse who took the original history, completed an addendum to Petitioner's request to change the method of injury. Therein, Ms. Ludvigsen stated that Petitioner made no mention of a history of hurting himself while moving furniture when he provided her with the initial history on July 27, 2009. RX 7. At trial, Petitioner denied sustaining a bicycle accident while intoxicated on July 27, 2009. He stated that "[m]y boss was working with me when I hurt my shoulder at work on a Thursday and when I - - I got drunk that evening but that Monday morning when I woke up my arm was hurting so bad I went back out to the hospital and that's when I - - my wife said he might have fell off the bike but I got hurt that Friday at work." Petitioner testified that he returned to Passavant Area Hospital on November 17, 2009 to dispute the history contained in his records because "I went to go see a lawyer because I found out it was carpal tunnel and a tear in my arm...and when I found out what it was I finally went to the doctor and told him that I needed surgery so I went to see a lawyer about taking the case and she said no, she couldn't take the case because they said I fell off a bike and I said that's not true...." Petitioner was unsure as to whether he had left shoulder pain from July 2009 until he saw Dr. Romanelli in late 2009, but he testified that he had left shoulder pain from when he hurt his shoulder moving furniture on July 24, 2009 until Dr. Romanelli performed surgery on November 24, 2009.

Petitioner presented to Dr. Hinchen on September 2, 2009 complaining of left shoulder pain. He reported that he awoke with a painful left shoulder two to three weeks prior. He denied any injury. Petitioner was assessed with arthritic changes in his left arm and possibly some ligamentous problems. Dr. Hinchen prescribed him Naprosyn and Tylenol for pain, and referred him to Dr. Senica. RX 6.

On September 17, 2009, Petitioner presented to Dr. Karolyn Senica at Orthopedic Center of Illinois. Petitioner reported that he had the left shoulder pain for the previous one and a half to two months, and he denied any injury or trauma. She diagnosed him with left shoulder impingement with possible rotator cuff pathology. Dr. Senica injected his left subacromial space and prescribed Mobic. RX 8.

Petitioner presented to Dr. Ronald Romanelli at Orthopedic Center of Illinois on October 28, 2009 and reported hurting his shoulder while moving furniture. Dr. Romanelli performed a left shoulder arthroscopy with arthroscopic rotator cuff repair, biceps tenodesis, subacromial decompression, and acromioclavicular joint resection on Petitioner on November 24, 2009. Post-

operatively, Petitioner returned to work without restrictions on March 3, 2010. RX 8. On May 7, 2010, Petitioner returned to Dr. Romanelli complaining of increasing pain and increasing discomfort in his left shoulder. "He is back to work, but he just not doing very well. He still feels weakness in his shoulder. He has been trying to do a little more lifting and a little more activities at work, but he is still having some issues. He says the pain is waking him up at night. He actually wants more pain medicine and this has been discussed with him." A physical examination of the left shoulder revealed "a lot of weakness" with good passive range of motion. Dr. Romanelli noted that, "I am impressed with his motion and he does not have a lot of stiffness, but he does have the weakness and that is a concern to me." Dr. Romanelli assessed him as status post arthroscopic rotator cuff repair of a massive tear, and he recommended Petitioner return in one month and continue physical therapy. PX 2, RX 8. Petitioner testified on direct-examination that following his surgical procedure with Dr. Romanelli in 2009, his left shoulder improved and that it "was doing a lot better." He denied experiencing any pain in his left shoulder from the time he was released to work on March 3, 2010 until his work accident on June 17, 2010. He testified on cross-examination that he was still recovering from his left shoulder surgery at the time of his work accident, and that he may have been experiencing weakness in his shoulder at that time. Petitioner also acknowledged undergoing injections to his right shoulder in 2000 or 2001, but he denied experiencing pain in his shoulders thereafter until after his work accident of June 17, 2010.

Dr. Romanelli testified by way of evidence deposition on July 18, 2012. Dr. Romanelli opined that Petitioner re-sprained or re-aggravated his left shoulder that "could indeed be" causally related to his fall on June 17, 2010, given that "a fall on an outstretched arm you can indeed cause, aggravate, tear a rotator cuff with that mechanism of injury." He stated that, "[s]o either the connection from the operation was not enough to cause the muscle to get as strong as it should be or he tore that full thickness - - or tore the portion of the supraspinatus tendon with his fall that caused him to have this weakness that persisted." Dr. Romanelli testified that on May 7, 2010, Petitioner returned to him with complaints of increasing pain and discomfort in his left shoulder, "not doing very well", and weakness in his left shoulder, which Dr. Romanelli explained is not uncommon for a large rotator cuff tear. Dr. Romanelli testified that if Petitioner's rotator cuff remained torn as time of the May 7, 2010 visit, then weakness would be one of his findings on physical examination. Dr. Romanelli further testified that his July 7, 2010 examination of Petitioner's left shoulder was the same as it was at the time of the May 7, 2010 examination, and he acknowledged that the MRI of the left shoulder taken subsequent to his June 17, 2010 work accident revealed no structural changes. PX 5.

Regarding the right shoulder, Dr. Romanelli opined that Petitioner's right shoulder sprain was directly related to his fall of June 17, 2010. Dr. Romanelli testified that his causal opinions were based upon the history provided to him by Petitioner of falling onto both outstretched hands. He testified that if Dr. Gordon took a history of Petitioner falling backward and landing on his buttocks and his left hand, but made no mention of his right hand, that would be inconsistent with the history Petitioner gave Dr. Romanelli. Dr. Romanelli acknowledged that, if Petitioner fell on June 17, 2010 with no history of landing on his right hand or striking any part of his right upper extremity, and no right shoulder complaints are noted in Dr. Gordon's records of June 18, 2010 or June 25, 2010, and that Petitioner reported to Dr. Gordon on July 9, 2010 that his right shoulder pain began a week prior, that his right shoulder was not involved in his work injury of June 17, 2010. PX 5.

Dr. Greene testified by way of evidence deposition on March 25, 2014. Dr. Greene testified that Petitioner reported a history of slipping on some water and falling backwards onto both outstretched hands at work on June 17, 2010. Based upon Petitioner's reported mechanism of injury and his history that he had worsening pain in his shoulders following his work accident, Dr. Greene opined that Petitioner's left shoulder condition and need for surgical intervention on December 23, 2010 was caused in part by his fall of June 17, 2010. Dr. Greene testified that the pulling away of the anchors in Petitioner's left shoulder placed there by Dr. Romanelli possibly could have been caused by his work accident. Dr. Greene testified that it was possible that Petitioner's work accident of falling onto his outstretched hand on June 17, 2010 caused in part the need for his right shoulder surgery. Dr. Greene stated that the history given to him of Petitioner falling backwards onto his right and left hands on June 17, 2010 was inconsistent with the history Petitioner gave to Dr. Gordon that he landed only on his left hand. He testified that his diagnosis of Petitioner's left shoulder was a rotator cuff tear and that such a condition would be caused by a number of factors other than trauma or a fall. Dr. Greene stated that he has treated other individuals with rotator cuff tears with no history of a fall or trauma. PX 6.

Petitioner was evaluated by Dr. Michael Milne on November 15, 2010 pursuant to Section 12 of the Act. Petitioner reported to Dr. Milne that on June 17, 2010, he slipped at work and landed on his buttocks and bilateral upper extremities. Petitioner further reported pain in both shoulders following the work accident. Dr. Milne reviewed radiographic studies of both shoulders, as well as Petitioner's medical records prior to the work accident, and he performed a physical examination. Dr. Milne diagnosed Petitioner with left shoulder partial versus full thickness rotator cuff re-tear, left shoulder residual acromioclavicular joint arthrosis, and right shoulder impingement. Dr. Milne opined that Petitioner's work accident of June 17, 2010 did not cause his left or right shoulder complaints. He further opined that if Petitioner experienced continued complaints in his left shoulder, he would recommend a repeat diagnostic arthroscopy with revision distal clavicle resection and possible revisions rotator cuff repair, the necessity of which he opined predated his June 17, 2010 accident. Dr. Milne opined that Petitioner did not require any additional medical treatment to his right shoulder relative to his work injury, though he stated he may require injections or a possible subacromial decompression if he continues to have pain in that shoulder. Dr. Milne stated that Petitioner was at maximum medical improvement for his bilateral shoulders relative to the alleged June 17, 2010 accident. RX 1.

Dr. Milne testified by way of evidence deposition on August 15, 2011. Dr. Milne testified that he was uncertain whether the work accident of June 17, 2010 was a cause of Petitioner's left upper extremity condition because "[i]t was my feeling as a I described in my IME report that Dr. Romanelli's notes showed this patient had pain and weakness prior to this injury that would concern me for a re-tear prior to the work-related injury." He opined that Petitioner's work accident was not a cause of Petitioner's right shoulder impingement because "I thought that he had likely caused increasing pain at that time. I didn't think that any structural change had occurred." Dr. Milne explained that the complaints and limitations Petitioner reported to Dr. Romanelli on May 7, 2010 were consistent with a recurrent rotator cuff tear. He stated that, "[t]here's also a possibility that the repair never healed completely, and looking at the operative note, the way that he placed the suture, also, one of them can become loose and not change the structural integrity of the repair." Dr. Milne further testified that his findings upon physical examination are consistent with post status left shoulder rotator cuff repair. RX 5.

CONCLUSIONS OF LAW

The Arbitrator finds Petitioner to be an incredulous witness and accordingly does not place evidentiary weight on his testimony. After observing his demeanor and testimony at Arbitration, the Arbitrator finds Petitioner's testimony to not be candid or forthright. Petitioner was oftentimes evasive and had difficulty recalling information on cross-examination. Petitioner testified on cross-examination that, "I don't remember what happened four years ago", though he was able to recall details from the same distant past with clarity and ease on direct-examination.

The Arbitrator finds that Petitioner's veracity is also called into question by the objective records in evidence. The Arbitrator notes that on direct-examination, Petitioner specifically denied experiencing any pain in his left shoulder from March 3, 2010 through June 17, 2010, and he testified that he had significantly improved following left shoulder surgery in November 2009. Yet, his treating records of Dr. Romanelli indicate otherwise. On May 7, 2010, Petitioner reported "increasing pain and increasing discomfort in his shoulder. He is back to work, but he just not doing very well. He still feels weakness in his shoulder. He has been trying to do a little more lifting and a little more activities at work, but he is still having some issues. He says that the pain is waking him up at night. He actually wants more pain medicine and this has been discussed with him. I told him that I am not recommending anymore pain medicine." PX 2. While Petitioner eventually recognized on cross-examination that he was still recovering from his November 23, 2009 left shoulder procedure and that he "may" have been experiencing some weakness in his left arm at the time of his work accident on June 17, 2010, his acknowledgement came only upon being confronted by Respondent's counsel and with Dr. Romanelli's records, which the Arbitrator finds demonstrative of Petitioner's disingenuousness on direct-examination.

Moreover, Petitioner testified on direct-examination that he felt pain in both his left and right shoulder contemporaneously with the work accident. However, his testimony is inconsistent with the absence of reports of any right shoulder symptomatology to Dr. Gordon on either June 18, 2010 or June 25, 2010. His testimony is also contradicted by his denial on July 9, 2010 of sustaining any injury to his right shoulder, as well as his reports to Dr. Gordon on that same date that he began experiencing right shoulder pain a week prior. Further, Petitioner's testimony regarding experiencing right shoulder pain contemporaneously with his work accident is undermined by the pain diagram Petitioner completed himself, which reflects only complaints in his left shoulder and low back. PX 1. Petitioner's testimony is also called into question by his testimony on cross-examination that he was unable to recall whether his shoulders were painful at the completion of his work day on his date of accident because "[b]ack then I was drinking a little bit so, you know, I'd get off, get me a drink and I guess I'd be all right and then I'd wake up and start feeling pain again." Simply put, not only is Petitioner's testimony inconsistent with his treating records, but if Petitioner cannot recall what symptoms he was experiencing following his alleged work accident, the Arbitrator questions how much evidentiary weight she can place on any of Petitioner's reported history of accident or symptomatology subsequent to his work accident.

Furthermore, Petitioner's testimony concerning his mechanism of accident is inconsistent with that he reported to Dr. Gordon. Petitioner testified at Arbitration, and reported to Dr. Romanelli, Dr. Greene, and Dr. Milne, that he slipped on the floor of the bathroom and fell on his buttocks, using both his hands to break his fall. However, Petitioner reported to Dr. Gordon the day after the accident that he only fell onto his left hand, calling into question the veracity of his claimed injury to his right arm. Although Petitioner testified that he informed Dr. Gordon that he

fell onto both hands, the Arbitrator notes that Dr. Gordon took an extensive history of accident from Petitioner on both June 18, 2010 and June 25, 2010, and his records are devoid of any reports of an injury or complaints involving Petitioner's right shoulder. PX 1. Petitioner's complaints of bilateral shoulder pain resultant from the work accident is also inconsistent with his reports to Company Nurse on June 18, 2010 that he injured only his low back as a result of his slip and fall at work on June 17, 2010. PX 1. Although Petitioner testified that he informed Company Nurse of pain in both shoulders as well as low back pain, the Arbitrator notes that the record references in two separate areas only Petitioner's lower back as involved in the incident. PX 1.

In addition, Petitioner acknowledged undergoing injections to his right shoulder in 2000 or 2001, but he denied experiencing pain in either shoulder thereafter until he sustained his work accident on June 17, 2010. His treating records demonstrate otherwise, as Petitioner presented to Dr. Hinchen in 2005 for bilateral shoulder pain (RX 6) and in 2009, Petitioner sustained an injury to his left shoulder for which he was surgically treated. RX 8. The Arbitrator notes that upon presenting to Dr. Hinchen on September 2, 2009 and Dr. Senica on September 17, 2009, Petitioner denied sustaining any injury or trauma to his left shoulder (RX 8), which calls into question the history given to Dr. Romanelli approximately one month later on October 28, 2009 of injuring his shoulder while moving furniture at work (RX 8), as well as his testimony at Arbitration regarding same. The Arbitrator finds the foregoing demonstrates the unreliability of the histories of accident Petitioner provides to his treating physicians, as well as the questionable veracity of his testimony at Arbitration.

The Arbitrator further finds Petitioner's credulity suspect by his attempt to amend the history contained in the emergency room records of Passavant Area Hospital of July 27, 2009 from injuring his left shoulder after falling of a bicycle while intoxicated to lifting furniture while at work. Although Petitioner testified that his wife gave the history of him falling off the bicycle to the emergency room personnel, his testimony is contradicted by the treatment records, which indicate Petitioner as the patient to be the historian, and quotes him as saying "I was drunk" and unable to recall how he injured his left shoulder. The original history Petitioner provided to the emergency personnel at Passavant on July 27, 2009 of falling of his bicycle while intoxicated is corroborated by Nurse Mary Ledvigsen, who completed an addendum to Petitioner's request to amend the history, and noted that Petitioner failed to report he was moving furniture when he proffered the history of accident on July 27, 2009. The Arbitrator finds the foregoing relevant to Petitioner's credibility and the weight to be applied to his testimony in the present matter.

In regard to disputed issue (C), Petitioner's claim regarding the issue of accident essentially rests upon his testimony. The Arbitrator notes that although Petitioner testified that Greg Elliot witnessed the accident, he did not call Mr. Elliott as a witness at trial to support his claim. Given the Arbitrator's conclusions as to Petitioner's credibility, and in light of the inconsistencies within his own testimony, and those between Petitioner's testimony and the record, and given the record in its entirety, the Arbitrator does not place any evidentiary weight on Petitioner's testimony. The Arbitrator finds that Petitioner's testimony, standing alone, is insufficient to support a finding of accident in this case.

In regard to disputed issue (F), the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that his current condition of ill-being is causally related to his work accident. With respect to his left shoulder, the Arbitrator notes that Petitioner failed to report suffering any injury to either his left or right shoulder when he notified Company Nurse of

his injury on June 18, 2010. PX 1. Moreover, upon presenting to Dr. Gordon on June 18, 2010, Petitioner reported that his left shoulder was essentially unchanged from his pre-accident condition. Dr. Romanelli's records of May 7, 2010, one month prior to Petitioner's work accident, reflect that that Petitioner was experiencing weakness in his left shoulder, persistent pain that awakened him at night, and continued difficulties with lifting and activities. A physical examination of the left shoulder on that date revealed weakness. Dr. Romanelli testified that his July 7, 2010 examination of Petitioner's left shoulder was the same as that on May 7, 2010 examination, one month prior to Petitioner's work accident, and he stated that the MRI of the left shoulder taken subsequent to his June 17, 2010 work accident revealed no structural changes. PX 5. The Arbitrator finds the absence of any change in Petitioner's symptoms, physical examination findings, or findings on his imaging studies negates the suggestion of any causal relationship between Petitioner's work accident and his current condition of ill-being in his left shoulder. While both Dr. Romanelli and Dr. Gordon causally related Petitioner's left shoulder condition to his work accident, it is unclear from both of the physicians' testimonies whether they were aware that Petitioner reported only low back injuries to Company Nurse on June 18, 2010, and did not note any left shoulder complaints at that time. It is also unclear whether Dr. Romanelli and Dr. Gordon were aware that at the time of Petitioner's accident, by his own admission, he could not recall what symptoms he was experiencing following his alleged work accident due to his frequent intoxication.

With respect to Petitioner's right shoulder, as with the left, the Arbitrator finds probative the lack of any complaints to his shoulders when he reported his accident to Company Nurse. PX 1. The Arbitrator notes that Petitioner reported to Dr. Gordon on June 18, 2010, he only fell onto his left hand, which negates the presence of a right shoulder injury. Petitioner completed a pain diagram on June 18, 2010 and he did not note any right shoulder complaints. PX 1. Petitioner also presented to Dr. Gordon on June 25, 2010, and absent from his records of both June 25, 2010 and June 18, 2010 are any reports of an injury or complaints involving Petitioner's right shoulder (PX 1), which the Arbitrator finds significant. The Arbitrator further notes that on July 9, 2010, Petitioner denied suffering an injury to his shoulder upon presentation to Dr. Gordon, and reported that his right shoulder complaints began approximately one-week prior. PX 1. This history of onset of right shoulder pain does not correlate with his work accident, and the aforementioned evidence undermines the suggestion of both an accident involving his right shoulder as well a causal connection between any work accident and his current condition. Although Dr. Romanelli and Dr. Greene proffered causation opinions as to Petitioner's right shoulder, the Arbitrator is not inclined to rely upon either opinion in this regard, given that both physicians' opinions were based upon Petitioner's reported history of a fall onto both outstretched arms, which is not consistent with the record. PX 1, 5, 6. Dr. Romanelli and Dr. Greene also both appear unaware that Petitioner did not give a history of landing on his right arm or right arm complaints when he sought treatment with Dr. Gordon on June 18, 2010 and June 25, 2010, or that on July 9, 2010, he report an onset date of one week prior and denied sustaining any right shoulder injury. PX 5, 6. Dr. Romanelli acknowledged that if the aforementioned facts were indeed present, he would opine that Petitioner's right shoulder was not involved in his work injury of June 17, 2010. PX 5. In light of the foregoing, the Arbitrator finds persuasive the opinions of Dr. Gordon, who opined that "[b]ased upon what Mr. Franklin did describe to me previous and based upon my prior evaluations, his right shoulder issues are not related to the incident of 6/17/10." PX 1. Dr. Gordon initially treated Petitioner following his work accident and took an extensive history from Petitioner on both June 18, 2010 and June 25, 2010, and the Arbitrator finds his opinions more informed and well-founded in the record than the opinions of Drs. Romanelli or Greene.

With respect to his low back, the Arbitrator notes that on June 25, 2010, eight days following his work accident, Petitioner noted that his lower back complaints were "notably improved", and approximately one month following his work accident, on July 23, 2010, he denied any functional limitations. On that date, Dr. Gordon noted that Petitioner's sacral/coccygeal contusion was doing very well and that he had "no impairment in this regard". Subsequently, Petitioner did not seek treatment for his low back until two and a half years later on December 10, 2013, when Petitioner presented to Dr. Hinchen with complaints of low back pain with some radiation into his hips after lifting a box of paper at work. Petitioner was prescribed Cyclobenzaprine at that time and ordered to undergo therapy. RX 6. Thereafter, on April 24, 2014, Petitioner presented to Dr. Anthony Griffin at Memorial Health Systems and complained of back and left flank pain. RX 1. The Arbitrator finds that his treating records following the alleged work accident of June 17, 2010 that reflect his low back complaints resolved soon thereafter, in conjunction with the treating records which indicate subsequent injuries involving his low back for which he sought treatment, demonstrate a lack of a causal relationship between the current condition in his low back and his alleged work accident.

Based upon the foregoing and the totality of the record, the Arbitrator concludes that Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accident that arose out of and in the course of his employment involving his left shoulder, right shoulder, and low back on June 17, 2010, and that his current condition of ill-being is causally related to his alleged work accident. 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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Tejeda,

Petitioner,

vs.

NO: 14WC 35671

16IWCC0456

Carl Buddig & Co,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 3 0 2016
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DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

TEJEDA, MARIA
Employee/Petitioner

Case# **14WC035671**

CARL BUDDIG & CO
Employer/Respondent

16IWCC0456

On 10/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1315 DWORKIN & MACIARIELLO
JULIO COSTA
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

4866 KNELL & O'CONNOR
ANDREW FERNANDEZ
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

FINDINGS

On **September 05, 2014,** Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the 52 weeks preceding the injury, Petitioner earned $27,274.00; the average weekly wage was **$524.50**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **1** dependent child.

Respondent ***has not paid*** all appropriate charges for all reasonable and necessary medical services.

ORDER

Due to the Arbitrator's finding that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment, all other issues are rendered moot.

Therefore, 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.

David A. Kane
Signature of Arbitrator

October 8, 2015
Date

OCT - 8 2015

prior and was unrelated to work. (Respondent's Ex. 8). On February 9, 2013, Dr. McClellan diagnosed Petitioner with patellofemoral compartment degenerative joint disease in her bilateral knees and administered an epidural steroid injection ("ESI") into the left knee. (Respondent's Ex. 8). Petitioner returned to Dr. McClellan on September 21, 2013 with complaints of pain, swelling, and grinding in her knees so Dr. McClellan administered ESIs into both knees. (Respondent's Ex. 8). Petitioner was also diagnosed with a Baker's cyst and posterior horn tear and mucoid degeneration in the right medial meniscus. (Respondent's Ex. 8). Petitioner testified that she only received injections into the left knee which was for arthritis. (Trial Transcript pp. 22-23). On December 14, 2013, Petitioner returned to Dr. McClellan with complaints that her knees felt worse and now stating that she got hurt at work 3-4 years prior when a co-worker stepped on her foot and she fell onto both knees. (Respondent's Ex. 8). On December 30, 2013, Petitioner underwent a right knee meniscectomy performed by Dr. McClellan. (Respondent's Ex. 8; Trial Transcript pp. 20-21). Despite completing approximately six weeks of physical therapy, Petitioner informed Dr. McClellan on February 8, 2014 that she did not feel capable of returning to work. (Respondent's Ex. 8). Dr. McClellan instructed Petitioner to continue with physical therapy and return to work on March 10, 2014, which she did not do because of right knee discomfort. (Respondent's Ex. 8). At a visit with Dr. McClellan on March 14, 2014, Petitioner was diagnosed with bursitis of the right knee but deemed able to return to work full duty effective on March 24, 2014. (Respondent's Ex. 8).

At trial, Petitioner asserted that she did not seek or receive treatment for her knees following March 14, 2014 up until the date of her alleged work accident of September 5, 2014. (Trial Transcript pp. 21-23; Respondent's Ex. 10). However, this is untrue as documented by the medical records. Petitioner

Ms. Spencer informed Petitioner that Respondent was only accepting restrictions for workers' compensation related accommodations. (Trial Transcript pp. 113-114, 116; Respondent's Ex. 5). Petitioner reacted with frustration and limped away. (Trial Transcript p. 117). Ms. Spencer heard that Petitioner suffered a work injury the next day which appeared suspicious to her because the injury occurred right after the accommodations were denied. (Trial Transcript p. 118).

The Petitioner did not have an alternative to receive work accommodations or take time off for her pre-existing knee condition as she had exhausted her Family and Medical Leave Act ("FMLA") benefits. (Trial Transcript p. 105, 125). Petitioner had an obstetrics surgery in 2009 and knee surgery in 2013 that she processed FMLA paperwork for. (Trial Transcript p. 97). As a result of the 2013 knee surgery, Petitioner used up her entire FMLA allotment which is 12 weeks (480 hours or 60 days) within a rolling calendar period (Trial Transcript p. 105, 125; Respondent's Ex. 3). By September 5, 2014, Petitioner was negative 13.5 hours meaning she used too much FMLA time which then affects her employee attendance record and Petitioner was docked points for missing work. (Trial Transcript pp. 106-107; Respondent's Ex. 3-c). Thus, Petitioner had used up all her FMLA leave prior to the alleged accident date and could not take time off absent a work accident. (Trial Transcript p. 105; Respondent's Ex. 3).

Petitioner alleged that on September 5, 2014, she injured her bilateral legs while at work. (Respondent's Ex. 1; Trial Transcript p. 10-12, 18). Petitioner stated she was working on the meat-slicer and slipped on a plastic bag that was on the floor while she was moving between her station and the meat container. (Trial Transcript p. 10-12). She reported that her right foot slipped on a plastic bag that was on the floor which she did not see; and, she

was diagnosed with a right knee strain and a left knee sprain and she was told to follow-up with an orthopedic doctor within 48 hours. (Respondent's Ex. 7; Trial Transcript p. 27). Petitioner's son and daughter were present and translated for her at Ingalls. (Trial Transcript p. 26).

Following a work injury, the injured employee's supervisor notifies David Streeter, Respondent's Health & Safety Manager, that there has been a possible work injury. (Trial Transcript p. 137). Mr. Streeter's normal business procedure is to check to see if a supervisor accident report is filled out, as well as an employee accident report and an eyewitness report. (Trial Transcript p. 137). In this instance, there was a supervisor report but no employee report and no eyewitness report. (Trial Transcript p. 137). Mr. Streeter thought this was odd as Associates are trained yearly on proper accident reporting and they know they must complete the aforementioned reports. (Trial Transcript p. 138).

Following notification of Petitioner's alleged work accident, Mr. Streeter did a personal investigation of the line area and interviewed all associates within the respective area—approximately 15-20 people—and no one said they saw Petitioner fall. (Trial Transcript p. 187). Mr. Streeter opined that this was odd as there are 5-9 lines running at a minimum at all times in the Vincennes plant where Petitioner worked. (Trial Transcript p. 171). Additionally, Line 41, the line Petitioner was working on, is in the middle of the floor which makes it unusual that the fall was unwitnessed as there are approximately 50 associates working in the plant at any given time. (Trial Transcript p. 141; Respondent's Ex. 6A, 5B). Of note, Petitioner's alleged accident occurred in September which is one of the busiest production times of the year so it was likely that all lines were running at the time of Respondent's alleged accident. (Trial Transcript p. 172).

no meat on the floor and nothing about the cement floor in the plant creates a tripping/slipping hazard. (Trial Transcript pp. 165-166).

On September 23, 2014, Petitioner signed her Application for Adjustment of claim, alleging a workplace injury affecting "both knees" (Respondent's Ex. 1). On September 24, 2014, Petitioner transferred her care from her prior orthopedic doctor, Dr. John McClellan, to AMCI South Holland. (Trial Transcript p. 28). Petitioner informed Dr. Dale Hooton that she was carrying a block of meat and fell, striking her left knee against a floor drain. (Respondent's Ex. 9). Petitioner testified that her left knee hurt more than the right when she presented to AMCI but the treatment notes indicate a physical exam of the left knee showed full and pain-free range of motion. (Trial Transcript p 28; Respondent's Ex. 9). Petitioner was diagnosed with a right knee sprain and taken off work duty until October 1, 2014. (Respondent's Ex. 9).

On October 1, 2014, Petitioner returned to AMCI South Holland and was examined by Dr. Michael Foreman. She reported bilateral knee pain, left worse than right, and claimed she was unable to stand or work as needed as no sedentary work was available. (Respondent's Ex. 9). This was in contradiction to Respondent's stated policy of accommodating any restrictions as a consequence of a work-related injury. (Trial Transcript p. 152). Dr. Foreman diagnosed knee sprains with underlying degenerative joint disease and recommended physical therapy. (Respondent's Ex. 9). Petitioner underwent physical therapy at AMCI three times per week from October 2, 2014 through December 23, 2014, with no significant improvement. (Respondent's Ex. 9).

On October 20, 2014, Petitioner returned to Dr. Foreman at AMCI. She denied any prior symptoms with her knees or knowledge of pre-existing degenerative joint disease. (Respondent's Ex. 9). MRI film was reviewed which indicated a possible degenerative tear in the left knee along with osteoarthritis

CONCLUSIONS OF LAW

C. In support of the Arbitrator's decision as to whether the Petitioner sustained an accident which arose out of and in the course of her employment with the Respondent, the Arbitrator makes the following findings:

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of her claim. *Peoria Nursing Home v. Industrial Comm'n,* 115 Ill.2d 524 (1987). Longstanding Illinois law mandates that a claimant must show that the injury is due to a cause connected to the employment to establish that it arose out of employment. *Elliot v. Industrial Commn,* 153 Ill.App.3d 238, 242 (1987). The burden of proof is upon a claimant to establish the elements of her right to compensation, and unless the evidence considered in its entirety supports a finding that the alleged injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Comm'n,* 44 Ill. 2d 214 (1969).

In the instant matter, the Arbitrator had the opportunity to observe the Petitioner when she testified. The Arbitrator also had the opportunity to examine the medical history of the Petitioner and the other evidence provided by the parties. Based upon the review of the medical records, the supervisor's statement, the FMLA documents, and especially the fact that Petitioner's testimony was contradictory to the facts as contained in the medical records and refuted by Respondent's witnesses, the Arbitrator concludes that the Petitioner is not a credible witness.

The Petitioner alleged that on September 5, 2014, she slipped and fell on a plastic bag she did not see that was on the ground while working at the meat

that she slipped on meat, not a plastic bag as she testified to at trial and reported to her medical providers. (Respondent's Ex. 2; Trial Transcript pp. 10-12, 80). Mr. Horton's supervisor accident report also notes that Petitioner claims her fall was unwitnessed, which she repeated at trial. (Respondent's Ex. 2; Trial Transcript pp. 13, 39). However, it is extremely unlikely, if not impossible, that Petitioner could have fallen and suffered her described accident without any witnesses as approximately 50 different people would have been working in Petitioner's immediate vicinity. (Trial Transcript pp. 141, 171-172, 191; Respondent's Ex. 6A).

Additionally, the described mechanism of injury is highly unlikely to have occurred as regular and thorough audits of the work stations are completed to ensure that there are no tripping dangers or other hazards around the production lines. (Trial Transcript pp. 161-163). There would be no reason for bags to be at the meat slicer position where Petitioner was stationed as the meat doesn't go into the bags until further down the line. (Trial Transcript p. 162). Bags are also never on the floor as there is a large garbage bin placed by the line for workers to throw empty bags away. (Trial Transcript pp. 164-165). Furthermore, there is a dedicated janitor who empties the garbage cans so they don't overflow. (Trial Transcript p. 165). There is no meat on the floor and nothing about the cement floor would create a tripping or slipping hazard. (Trial Transcript pp. 165-166). The drain which Petitioner alleges she fell on is flush with the ground and would not be a tripping hazard. (Trial Transcript p. 163; Respondent's Ex. 6H). Mr. Streeter himself conducts regular audits of the work areas in the Vincennes plant to observe for any possible hazards and verified there are never tripping hazards on the floor and he has no prior experience with employees tripping while loading meat logs onto a slicer. (Trial Transcript p. 161).

completed several classes of ESL provided by Respondent. (Trial Transcript p. 123).

Finally, Petitioner had motive to allege a false work injury as she did not want to work extended hours because of her pre-existing knee condition but she had exhausted her FMLA benefits. (Trial Transcript pp. 105-107, 125, 134; Respondent's Ex. 3-4). As a result of her 2013 knee surgery, Petitioner used up her entire FMLA allocation of 12 weeks within a rolling calendar period. (Trial Transcript p. 105, 125). When Petitioner discussed work accommodations with Ms. Spencer on September 4, 2014, she was negative 13.5 hours of FMLA leave which meant she used too much FMLA time and received a disciplinary point for missing work. (Trial Transcript p. 106-107). An employee's FMLA allocation is only renewed once an employee has earned enough work hours—1250 hours—and the employee still has time available within the rolling calendar period, which Petitioner did not. (Trial Transcript p. 108-109). During her conversation with Ms. Spencer, Petitioner was informed that because she did not have FMLA time available, the company could not accommodate her restrictions as they were not related to a work injury and she could only have restrictions accommodated if she had a work accident. (Trial Transcript p. 116). The following day, September 5, 2014, Petitioner alleged the slip and fall at work. (Respondent's Ex. 1).

Considering the totality of the evidence – the fact that Petitioner lied on the stand, several times, regarding the alleged mechanism of injury; that Petitioner omitted details regarding idiopathic fainting episodes; the nearly impossible lack of witnesses to the alleged fall; her medical history and treatment for her knee conditions; her ability to speak English; and the lack of FMLA benefits available rendering her unable to work with accommodations absent a work injury, all rendering Petitioner's credibility suspect—the Arbitrator

Comm'n, 371 Ill.App.3d 882 (5th Dist. 2007). The question of causal relationship is a question of fact for the Commission. *Chicago Park Dist. v. Indus. Comm'n,* 36 Ill.2d 212 (1966).

Having established that the Petitioner's testimony and credibility is unreliable, the Arbitrator next turns to expert opinions on causation. It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise, or conjecture. *Wilfert v. Retirement Board,* 318 Ill.App.3d 507, 514-15 (1st Dist. 2000).

Dr. Cole stated that it was likely Petitioner suffered a work-related aggravation of preexisting osteoarthritis to her bilateral knees as a result of her fall (Respondent's Ex. 10); however, this opinion cannot be given weight since the Petitioner withheld treatment information. Dr. Cole expressly stated that his causation opinion could change if Petitioner had been treating for her knees in the 6 months prior to the alleged work accident. (Respondent's Ex. 10). At the time of the IME evaluation, Petitioner did not disclose to Dr. Cole that she had been treating with Dr. Khaleel for her knee as recently as the day before the alleged work injury and Respondent had not yet located the records from Dr. Khaleel's office to provide to Dr. Cole. (Respondent's Ex. 10). Additionally, because Dr. Cole did not have Dr. Khaleel's treatment records, Dr. Cole could not have known about the Petitioner's other medications and her fainting episodes which call into question the true mechanism that aggravated Petitioner's degenerative condition. Furthermore, and even absent this relevant information, Dr. Cole cautiously opined that he "cannot state categorically that need for care of the right and left knees is related to the (alleged) injury." (Respondent's Ex. 10).

Due to the Arbitrator's findings on the issues of accident and causation, all other issues are rendered moot.

Therefore, compensation is hereby denied.